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Virginia Register of Regulations

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THE VIRGINIA REGISTER OF REGULATIONS (USPS-001831) is published biweekly, with quarterly cumulative indices published in January, April, July and October, for $188.00 per year by LexisNexis Matthew Bender, 1275 Broadway, Albany, NY 12204. Periodical postage is paid at Albany, NY and at additional mailing offices. POSTMASTER: Send address changes to LexisNexis Matthew Bender, 1275 Broadway, Albany, NY 12204.

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

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

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

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

A regulation becomes effective at the conclusion of the 30-day final adoption period, or at any other later date specified by the promulgating agency, unless (i) a legislative objection has been filed, in which event the regulation, unless withdrawn, becomes effective on the date specified, which shall be after the expiration of the 21-day objection period; (ii) the Governor exercises his authority to require the agency to provide for additional public comment, in which event the regulation, unless withdrawn, becomes effective on the date specified, which shall be after the expiration of the period for which the Governor has provided for additional public comment; (iii) the Governor and the General Assembly exercise their authority to suspend the effective date of a regulation until the end of the next regular legislative session; or (iv) the agency suspends the regulatory process, in which event the regulation, unless withdrawn, becomes effective on the date specified, which shall be after the expiration of the 30-day public comment period and no earlier than 15 days from publication of the readopted action.

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

Pursuant to § 2.2-4011 of the Code of Virginia, an agency, upon consultation with the Attorney General, and at the discretion of the Governor, may adopt emergency regulations that are necessitated by an emergency situation. An agency may also adopt an emergency regulation when Virginia statutory law or the appropriation act or federal law or federal regulation requires that a regulation be effective in 280 days or less from its enactment. The emergency regulation becomes operative upon its adoption and filing with the Registrar of Regulations, unless a later date is specified. Emergency regulations are limited to no more than 12 months in duration; however, may be extended for six months under certain circumstances as provided for in § 2.2-4011 D. Emergency regulations are published as soon as possible in the *Register*.

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

STATEMENT

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

CITATION TO THE *VIRGINIA REGISTER*

The *Virginia Register* is cited by volume, issue, page number, and date. **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.

PUBLICATION SCHEDULE AND DEADLINES

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

May 2010 through June 2011

Volume: Issue	Material Submitted By Noon*	Will Be Published On
26:19	May 5, 2010	May 24, 2010
26:20	May 18, 2010 **(Tuesday)**	June 7, 2010
26:21	June 2, 2010	June 21, 2010
26:22	June 16, 2010	July 5, 2010
26:23	June 30, 2010	July 19, 2010
26:24	July 14, 2010	August 2, 2010
26:25	July 28, 2010	August 16, 2010
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27:17	April 6, 2011	April 25, 2011
27:18	April 20, 2011	May 9, 2011
27:19	May 4, 2011	May 23, 2011
27:20	May 18, 2011	June 6, 2011
27:21	June 1, 2011	June 20, 2011

*Filing deadlines are Wednesdays unless otherwise specified.

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARD OF OPTOMETRY

Agency Decision

Title of Regulation: **18VAC105-20. Regulations Governing the Practice of Optometry.**

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

Name of Petitioner: Dennis M. Garcia.

Nature of Petitioner's Request: To amend regulations to prohibit provisions in a lease that control or attempt to control malpractice liability coverage, patient records, and scheduling of patient appointments.

Agency Decision: Request denied.

Statement of Reasons for Decision: The board considered this petition and voted to deny the request because it believes the current laws and regulations in Virginia concerning attempts to control an optometrist's practice are adequate to protect the public.

Agency Contact: Leslie Knackel, Executive Director, Board of Optometry, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4508, FAX (804) 527-4466, or email leslie.knackel@dhp.virginia.gov.

VA.R. Doc. No. R10-32; Filed May 5, 2010, 4:08 p.m.

TITLE 4. CONSERVATION AND NATURAL RESOURCES

MARINE RESOURCES COMMISSION

Final Regulation

REGISTRAR'S NOTICE: The following regulations filed by the Marine Resources Commission are 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: **4VAC20-490. Pertaining to Sharks (amending 4VAC20-490-20, 4VAC20-490-44).**

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

Effective Date: May 1, 2010.

Agency Contact: Jane Warren, Agency Regulatory Coordinator, Marine Resources Commission, 2600 Washington Ave., 3rd Floor, Newport News, VA 23607, telephone (757) 247-2248, FAX (757) 247-2002, or email betty.warren@mrc.virginia.gov.

Summary:

The amendments (i) define "agent"; (ii) prohibit the use of agents in the spiny dogfish fishery; and (iii) allow the commissioner or his designee to grant exceptions to the prohibition against transfers of the spiny dogfish limited entry fishery permit.

4VAC20-490-20. Definitions.

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

"Agent" means any person who possesses the Commercial Fisherman Registration License, fishing gear license, or fishing permit of a registered commercial fisherman in order to fish that commercial fisherman's gear or sell that commercial fisherman's harvest.

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

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

"Commercial shark fishermen" means any commercially permitted fisherman who has landed and sold one pound of shark or more (excludes spiny dogfish) in that calendar year (January 1 through December 31).

"Commercially permitted nonsandbar large coastal shark" means any of the following species:

Blacktip, Carcharhinus limbatus

Bull, Carcharhinus leucas

Great hammerhead, Sphyrna mokarran

Lemon, Negaprion brevirostris

Nurse, Ginglymostoma cirratum

Scalloped hammerhead, Sphyrna lewini

Silky, Carcharhinus falciformis

Smooth hammerhead, Sphyrna zygaena

Spinner, Carcharhinus brevipinna

Tiger, Galeocerdo cuvier

"Commercially permitted pelagic shark" means any of the following species:

Blue, Prionace glauca

Oceanic whitetip, Carcharhinus longimanus

Porbeagle, Lamna nasus

Shortfin mako, Isurus oxyrinchus

Thresher, Alopias vulpinus

"Commercially permitted small coastal shark" means any of the following species:

Atlantic sharpnose, Rhizoprionodon terraenovae

Blacknose, Carcharhinus acronotus

Bonnethead, Sphyrna tiburo

Finetooth, Carcharhinus isodon

"Commercially prohibited shark" means any of the following species:

Atlantic angel, Squatina dumeril

Basking, Cetorhinus maximus

Bigeye sand tiger, Odontaspis noronhai

Bigeye sixgill, Hexanchus nakamurai

Bigeye thresher, Alopias superciliosus

Bignose, Carcharhinus altimus

Caribbean reef, Carcharhinus perezii

Caribbean sharpnose, Rhizoprionodon porosus

Dusky, Carcharhinus obscurus

Galapagos, Carcharhinus galapagensis

Longfin mako, Isurus paucus

Narrowtooth, Carcharhinus brachyurus

Night, Carcharhinus signatus

Sand tiger, Carcharias taurus

Sevengill, Heptranchias perlo

Sixgill, Hexanchus griseus

Smalltail, Carcharhinus porosus

Whale, Rhincodon typus

White, Carcharodon carcharias

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

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

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

"Fork length" means the straight-line measurement of a fish from the tip of the snout to the fork of the tail. The measurement is not made along the curve of the body.

"Movable gill net" means any gill net other than a staked gill net.

"Large mesh gill net" means any gill net having a stretched mesh equal to or greater than five inches.

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

"Permitted commercial gear" means rod and reel, handlines, shark shortlines, small mesh gill nets, large mesh gill nets, pound nets, and weirs.

"Recreational shore angler" means a person not fishing from a vessel nor transported to or from a fishing location by a vessel.

"Recreational vessel angler" means a person fishing from a vessel or transported to or from a fishing location by a vessel.

"Recreationally permitted shark" means any of the following species:

Atlantic sharpnose, Rhizoprionodon terraenovae

Blacknose, Carcharhinus acronotus

Blacktip, Carcharhinus limbatus

Blue, Prionace glauca

Bonnethead, Sphyrna tiburo

Bull, Carcharhinus leucas

Finetooth, Carcharhinus isodon

Great hammerhead, Sphyrna mokarran

Lemon, Negaprion brevirostris

Nurse, Ginglymostoma cirratum

Oceanic whitetip, Carcharhinus longimanus

Porbeagle, Lamna nasus

Scalloped hammerhead, Sphyrna lewini

Shortfin mako, Isurus oxyrinchus

Smooth dogfish, Mustelus canis

Smooth hammerhead, Sphyrna zygaena

Spinner, Carcharhinus brevipinna

Thresher, Alopias vulpinus

Tiger, Galeocerdo cuvier

"Recreationally prohibited shark" means any of the following species:

Atlantic angel, Squatina dumeril

Basking, Cetorhinus maximus

Bigeye sand tiger, Odontaspis noronhai

Bigeye sixgill, Hexanchus nakamurai

Bigeye thresher, Alopias superciliosus

Bignose, Carcharhinus altimus

Caribbean reef, Carcharhinus perezii

Caribbean sharpnose, Rhizoprionodon porosus

Dusky, Carcharhinus obscurus

Galapagos, Carcharhinus galapagensis

Longfin mako, Isurus paucus

Narrowtooth, Carcharhinus brachyurus

Night, Carcharhinus signatus

Sand tiger, Carcharias taurus

Sandbar, Carcharhinus plumbeus

Sevengill, Heptranchias perlo

Silky, Carcharhinus falciformis

Sixgill, Hexanchus griseus

Smalltail, Carcharhinus porosus

Whale, Rhincodon typus

White, Carcharodon carcharias

"Research only shark" means any of the following species:

Sandbar, Carcharhinus plumbeus

"Shark shortline" means a fish trotline that is set horizontally, either anchored, floating or attached to a vessel, and that consists of a mainline or groundline, 1,000 feet in length or less, with multiple leaders (gangions) and no more than 50 corrodible circle hooks, whether retrieved by hand or mechanical means.

"Small mesh gill net" means any gill net having a stretched mesh less than five inches.

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

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

4VAC20-490-44. Spiny dogfish limited entry fishery permit and permit transfers.

A. It shall be unlawful for any person to take, catch, possess, or land any spiny dogfish without first having obtained a spiny dogfish limited entry fishery permit from the Marine Resources Commission. Such permit shall be completed in full by the permittee who shall keep a copy of that permit in his possession while fishing for or selling spiny dogfish. Permits shall only be issued to Virginia registered commercial fishermen meeting either of the following criteria:

1. Shall have documented on Virginia mandatory harvest reporting forms harvest from a legally licensed, movable gill net for an average of at least 60 days from 2006 through 2008, and a minimum harvest of one pound of spiny dogfish at any time from 2006 through 2008.

2. Shall have documented on Virginia mandatory reporting forms harvests that total greater than 10,000 pounds of spiny dogfish in any one year from 2006 through 2008.

B. It is unlawful to transfer any spiny dogfish limited entry fishery permit after November 23, 2009.

C. The use of agents in the spiny dogfish fishery is prohibited.

D. The commissioner or his designee may grant exceptions to the prohibition against transfers of the spiny dogfish limited entry fishery permit as described in subsection B of this section to any individual who meets any of the following criteria:

1. Demonstrates a significant hardship on the basis of health and provides the commissioner documentation, by an attending physician, of the medical condition.

2. Demonstrates a significant hardship on the basis of a call to active military duty and provides the commissioner an explanation, in writing, and copy of the military orders for active duty.

3. Documents the retirement or death of the immediate family member permitted for the spiny dogfish limited entry fishery and possessing a legal Commercial Fisherman Registration License.

VA.R. Doc. No. R10-2374; Filed April 30, 2010, 2:18 p.m.

Final Regulation

Title of Regulation: **4VAC20-560. Pertaining to Shellfish Management Areas (amending 4VAC20-560-40).**

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

Effective Date: May 1, 2010.

Agency Contact: Jane Warren, Agency Regulatory Coordinator, Marine Resources Commission, 2600 Washington Ave., 3rd Floor, Newport News, VA 23607, telephone (757) 247-2248, FAX (757) 247-2002, or email betty.warren@mrc.virginia.gov.

Summary:

This amendment changes the 2010 season for the harvest of clams by patent tong from the Newport News Shellfish Management Area to January 1, 2010, through June 30, 2010, and December 1, 2010, through December 31, 2010, and makes it unlawful for any person to harvest clams by patent tong from such area from July 1, 2010, through November 30, 2010.

4VAC20-560-40. Patent tong season.

A. The lawful season for the harvest of clams by patent tong from the York River Shellfish Management Area shall be August 15 through November 30.

B. The lawful season for the harvest of clams by patent tong from the Poquoson River Shellfish Management Area shall be March 15 through May 1.

C. The lawful season for the harvest of clams by patent tong from the Back River Shellfish Management Area shall be January 1 through March 31.

D. It shall be unlawful for any person to harvest clams by patent tong from either the York River, Poquoson River, or

Back River Shellfish Management Area except as provided in subsections A, B, and C of this section.

E. ~~The~~ Except as provided in subsection G of this section, the lawful season for the harvest of clams by patent tong from the Newport News Shellfish Management Area shall be December 1 through April 30, except that if the catch of clams per tong-hour for the previous season is less than 174 clams per tong-hour, the lawful season shall be December 1 through March 31.

F. ~~It~~ Except as provided in subsection G of this section, it shall be unlawful for any person to harvest clams by patent tong from the Newport News Shellfish Management Area from May 1 through November 30, except that if the catch of clams per tong-hour for the previous season is less than 174 clams per tong-hour, it shall be unlawful for any person to harvest clams by patent tong from the Newport News Shellfish Management Area from April 1 through November 30.

G. The lawful season for the harvest of clams by patent tong from the Newport News Shellfish Management Area shall be January 1, 2010, through June 30, 2010, and December 1, 2010, through December 31, 2010. It shall be unlawful for any person to harvest clams by patent tong from the Newport News Shellfish Management Area from July 1, 2010, through November 30, 2010.

VA.R. Doc. No. R10-2375; Filed April 30, 2010, 2:15 p.m.

Final Regulation

Title of Regulation: **4VAC20-720. Pertaining to Restrictions on Oyster Harvest (amending 4VAC20-720-10, 4VAC20-720-60, 4VAC20-720-110; repealing 4VAC20-720-106).**

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

Effective Date: May 1, 2010.

Agency Contact: Jane Warren, Agency Regulatory Coordinator, Marine Resources Commission, 2600 Washington Ave., 3rd Floor, Newport News, VA 23607, telephone (757) 247-2248, FAX (757) 247-2002, or email betty.warren@mrc.virginia.gov.

Summary:

The amendments (i) make it unlawful for any person to harvest or attempt to harvest oysters prior to sunrise or after 2 p.m. from certain areas, except as described in new chapter 4VAC20-1230, which is contained in the next regulatory action and (ii) repeal 4VAC20-720-106, which is being replaced by 4VAC20-1230.

4VAC20-720-10. Purpose.

The purpose of this chapter is to protect and conserve Virginia's oyster resource, and promote the preservation of oyster broodstock, which has been depleted by disease, harvesting, and natural disasters~~, and protect the public health~~.

4VAC20-720-60. Day and time limit.

A. It shall be unlawful to take, catch, or possess oysters on Saturday and Sunday from the public oyster grounds or unassigned grounds in the waters of the Commonwealth of Virginia, except that this provision shall not apply to any person harvesting no more than one bushel per day by hand or ordinary tong for household use only during the season when the public oyster grounds or unassigned grounds are legally open for harvest. The presence of any gear normally associated with the harvesting of oysters on board the boat or other vehicle used during any harvesting under this exception shall be prima facie evidence of violation of this chapter.

B. It shall be unlawful for any person to harvest or attempt to harvest oysters prior to sunrise or after 2 p.m. from the areas described in subdivisions 1, 3, 5, 6, and 7 of 4VAC20-720-40, except as described in ~~4VAC20-720-106~~ 4VAC20-1230. In addition, it shall be unlawful for any boat with an oyster dredge aboard to leave the dock until one hour before sunrise or return to the dock after sunset, and it shall be unlawful for any boat with a hand scrape aboard to leave the dock until one-half hour before sunrise or return to the dock after sunset.

C. It shall be unlawful for any person to harvest or attempt to harvest oysters in the area as described in subdivision 4 of 4VAC20-720-40 prior to 7 a.m. and after 1 p.m.

4VAC20-720-106. ~~Public health and warm water harvest restrictions.~~ (Repealed.)

~~A. It shall be unlawful for any person to have any cat, dog, or other animal on board a vessel during the harvest of oysters.~~

~~B. From May 1 through September 30, any vessel used for the harvest of oysters for human consumption from either public or private grounds shall have shading over the area that serves as storage for the oysters (except as described in subsection C of this section), and all oysters in the vessel shall be offloaded every day.~~

~~C. From May 1 through September 30, any vessel used for the harvest of oysters for human consumption that are placed in an aquaculture container completely covered by a lid or top, shall not be required to have shading over that container.~~

~~D. From June 15 through August 31, it shall be unlawful for any person, or person aboard a vessel, to leave the dock or shore prior to one hour before sunrise to harvest or attempt to harvest oysters from private grounds.~~

~~E. From May 1 through June 14, it shall be unlawful to harvest oysters for human consumption from public or private grounds after 11 a.m., and oysters harvested before 11 a.m. shall be refrigerated by 11 a.m. that same day.~~

~~F. From June 15 through August 31, it shall be unlawful to harvest oysters for human consumption from public or private grounds after 10 a.m., and oysters harvested before 10 a.m. shall be refrigerated by 10 a.m. that same day.~~

~~G. From September 1 through September 30, it shall be unlawful to harvest oysters for human consumption from public or private grounds after 12 p.m., and oysters harvested before 12 p.m. shall be refrigerated by 12 p.m. that same day.~~

~~H. Subsections E, F, and G of this section shall not apply to the harvest of seed oysters or the customary husbandry processes associated with aquaculture of oysters.~~

~~I. Oysters may be harvested after the end of the designated harvesting time in subsections E, F, and G of this section provided there is a Virginia Department of Health, Division of Shellfish Sanitation approved refrigeration system or ice storage area for the oysters on board the harvest vessel that is in use for cooling oysters at all times or the total time expended on harvesting those oysters does not exceed two hours from start of harvest to refrigeration of those oysters, and there is verifiable documentation, such as a log book or GPS trip log that corresponds to that harvesting event.~~

4VAC20-720-110. Penalty.

A. As set forth in § 28.2-903 of the Code of Virginia, any person violating any provision of this chapter shall be guilty of a Class 3 misdemeanor and a second or subsequent violation of any provision of this chapter committed by the same person within 12 months of a prior violation is a Class 1 misdemeanor.

B. In addition to the penalty prescribed by law, any person violating any provisions of this chapter shall return all oysters in possession to the water, shall cease harvesting on that day, all harvesting apparatus shall be subject to seizure and pursuant to § 28.2-232 of the Code of Virginia shall be subject to the immediate forfeiture of all oyster licenses and permits until appearing before the Marine Resources Commission.

~~C. In addition to the penalty prescribed by § 28.2-802 of the Code of Virginia, any person violating any provisions of 4VAC20-720-106 shall destroy all oysters harvested by that person in violation of 4VAC20-720-106 in the presence of a marine police officer, and shall be subject to the immediate forfeiture of all oyster licenses and permits until appearing before the Marine Resources Commission.~~

VA.R. Doc. No. R10-2355; Filed April 30, 2010, 2:09 p.m.

Final Regulation

Title of Regulation: **4VAC20-1230. Pertaining to Restrictions on Shellfish (adding 4VAC20-1230-10 through 4VAC20-1230-40).**

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

Effective Date: May 1, 2010.

Agency Contact: Jane Warren, Agency Regulatory Coordinator, Marine Resources Commission, 2600 Washington Ave., 3rd Floor, Newport News, VA 23607, telephone (757) 247-2248, FAX (757) 247-2002, or email betty.warren@mrc.virginia.gov.

Summary:

This chapter establishes harvest times and handling procedures for shellfish harvested during the months of May through September to protect the public health. Definitions are included to explain the particular requirements established by this chapter. Penalties for violating any provision of the chapter are also included.

CHAPTER 1230
PERTAINING TO RESTRICTIONS ON SHELLFISH

4VAC20-1230-10. Purpose.

The purpose of this chapter is to establish harvest times and handling procedures for shellfish harvested during the months of May through September to protect the health of the public.

4VAC20-1230-20. Definitions.

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

"Harvest" means the act of removing shellfish from a designated harvest area and placing that harvest on or in a man-made conveyance or other means of transport.

"Mechanical refrigeration" means storage in a container that is approved by the Virginia Department of Health Division of Shellfish Sanitation and capable of cooling to and maintaining an ambient temperature of 45°F or less.

"Oysters" mean those oysters greater than 2-1/2 inches in shell length.

"Shading" means to shelter by intercepting the direct rays of the sun to protect the shellfish from heat, using a tarp or cover.

"Shellfish" means all species of bivalve molluscan shellfish.

"Time to refrigeration" means the amount of time from when the harvested shellstock is no longer within the water column to when it is refrigerated.

4VAC20-1230-30. Public health and warm water harvest restrictions.

A. It shall be unlawful for any person to have any cat, dog, or other animal on board a vessel during the harvest of shellfish.

B. From May 1 through September 30, any vessel used for the harvest of shellfish, from either public or private grounds, shall provide adequate air flow through and shading over the

area that serves as storage for the shellfish. All shellfish in the vessel shall be offloaded every day.

C. From May 1 through September 30, all land-based deliveries of shellfish requiring more than 30 minutes from landing that shellfish shall be made aboard trucks or conveyances equipped with mechanical refrigeration having an ambient temperature of 45°F or less before loading begins, except that shellfish may be thoroughly iced according to procedures approved by the Virginia Department of Health (VDH) Division of Shellfish Sanitation. Mechanically refrigerated containers shall be in operation from the time of loading to the time of offloading. Any operator of a truck that is delivering shellfish using a truck not owned by a certified shellfish dealer shall possess a truck refrigeration certificate issued by the VDH Division of Shellfish Sanitation. Upon receipt of any shellfish at the shore-based plant, certified shellfish dealers must immediately place any shellfish received from the harvester under mechanical refrigeration.

D. From June 15 through August 31, it shall be unlawful for any person or person aboard a vessel to leave the dock or shore prior to one hour before sunrise to harvest or attempt to harvest oysters from private grounds.

E. From May 1 through June 14, it shall be unlawful for any person or person aboard a vessel to harvest oysters from public or private grounds after 11 a.m., and oysters harvested before 11 a.m. shall be offloaded and placed in VDH Division of Shellfish Sanitation-approved mechanical refrigeration or storage containers with ice by 11 a.m. that same day.

F. From June 15 through August 31, it shall be unlawful for any person or person aboard a vessel to harvest oysters from public or private grounds after 10 a.m., and oysters harvested before 10 a.m. shall be offloaded and placed in VDH Division of Shellfish Sanitation-approved mechanical refrigeration or storage containers with ice by 10 a.m. that same day.

G. From September 1 through September 30, it shall be unlawful for any person or person aboard a vessel to harvest oysters from public or private grounds after noon, and oysters harvested before noon shall be offloaded and placed in VDH Division of Shellfish Sanitation-approved mechanical refrigeration or storage containers with ice by noon that same day.

H. Except as described in subsections K and L of this section, oysters may be harvested after the designated harvesting time in subsections E, F, and G of this section, provided (i) the total time, from the time the vessel leaves the dock or shore until the oysters are offloaded from the vessel and placed in VDH Division of Shellfish Sanitation-approved mechanical refrigeration or storage containers with ice, shall not exceed five hours; (ii) there is a Virginia Marine Resources Commission-approved Global Positioning System tracking device on board the harvest vessel that is in continuous operation from the time that vessel leaves the dock or shore until the vessel returns to the dock, and the oysters are offloaded from that vessel; and (iii) the harvester has applied for and been granted a permit by the Virginia Marine Resources Commission to harvest oysters after these designated harvesting times, and the harvester has designated a single landing site for that permit.

I. Any person who violates subsection H of this section shall be subject to immediate forfeiture of his Virginia Marine Resources Commission harvesting permit until such time that person appears before the commission.

J. From May 1 through September 30, a Bulk Seed Permit shall be obtained from the Virginia Marine Resources Commission for the harvest of any seed oysters that are greater than 2-1/2 inches. Any person who harvests any seed oysters greater than 2-1/2 inches and is not in possession of a Bulk Seed Permit issued by the Virginia Marine Resources Commission shall be in violation of this chapter.

K. Any person may handle oysters as part of a cage aquaculture operation for husbandry purposes after the designated harvesting times described in subsections E, F, and G of this section, provided that person possesses a valid Cage Aquaculture Husbandry Permit from the Virginia Marine Resources Commission. Any person who handles oysters in cage oyster aquaculture operations after the designated harvesting times described in subsections E, F, and G of this section and does not possess a Cage Oyster Aquaculture Husbandry Permit issued by the Virginia Marine Resources Commission shall be in violation of this chapter.

L. Oysters may be harvested in open areas of the James River and its adjacent tributaries, upstream from the Monitor Merrimac Memorial Bridge Tunnel, in addition to the designated harvesting times in subsections E, F, and G of this section, provided (i) there is a VDH Division of Shellfish Sanitation-approved refrigeration unit or ice storage area on board the harvesting vessel; (ii) the harvester has applied for and been issued a VDH Division of Shellfish Sanitation Vessel approval certificate that is required to be on board the vessel at all times during the harvest of oysters and has designated a single landing site for that permit; and (iii) the oysters are placed in an operating refrigeration unit or ice is applied to the oysters from the start of harvest and throughout the harvest period until the oysters are offloaded.

4VAC20-1230-40. Penalty.

A. In addition to the penalty prescribed by law, any person violating any provision of this chapter shall destroy, in the presence of a marine police officer, all shellfish in his possession and cease harvesting on that day. All harvesting apparatus shall be subject to seizure and, pursuant to § 28.2-232 of the Code of Virginia, all licenses and permits shall be subject to immediate forfeiture, until that person appears before the Marine Resources Commission.

B. As set forth in § 28.2-903 of the Code of Virginia, any person violating any provision of this chapter shall be guilty of a Class 3 misdemeanor, and a second or subsequent violation of any provision of this chapter committed by the same person within 12 months of a prior violation is a Class 1 misdemeanor.

VA.R. Doc. No. R10-2335; Filed April 30, 2010, 2:05 p.m.

TITLE 8. EDUCATION

STATE BOARD OF EDUCATION

REGISTRAR'S NOTICE: The reserved sections shown in the following State Board of Education proposed Regulations Governing Local School Boards and School Divisions (8VAC20-720) were published in 26:1 VA.R. 38-43 September 14, 2009. The following two regulatory actions repeal current outdated regulations and replace them with provisions in proposed 8VAC20-720 relating to (i) student fees and charges and (ii) textbooks and instructional materials, respectively.

Proposed Regulation

Titles of Regulations: **8VAC20-370. Rules Governing Fees and Charges (repealing 8VAC20-370-10).**

8VAC20-720. Regulations Governing Local School Boards and School Divisions (adding 8VAC20-720-10 through 8VAC20-720-170).

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

Public Hearing Information:

June 3, 2010 - 7 p.m. - Marion Senior High School, 848 Stage Street, Marion, VA

June 10, 2010 - 7 p.m. - T. C. Williams High School, 3330 King Street, Alexandria, VA

June 10, 2010 - 7 p.m. - Jolliff Middle School, 1021 Jolliff Road, Chesapeake, VA

June 10, 2010 - 7 p.m. - James River High School, 3700 James River Road, Midlothian, VA

Public Comment Deadline: July 26, 2010.

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

Basis: Section 22.1-16 of the Code of Virginia authorizes the Board of Education to adopt bylaws for its own governance and promulgate such regulations as may be necessary to carry out its powers and duties and the provisions of Title 22.1 of the Code of Virginia. Additionally, § 22.1-6 of the Code of Virginia limits the fees that may be charged to those that are permitted by state law or Board of Education regulations.

Purpose: The purpose of this proposal is to repeal the current regulations governing fees charged by local school divisions and create new better defined and updated provisions that will be added as a section to the proposed Regulations Governing Local School Boards and School Divisions, 8VAC20-720 once they become final. The current regulations governing fees and charges will be repealed simultaneously with the adoption of the addition to the Regulations Governing Local School Boards and School Divisions.

The proposed regulatory action will have no negative impact on the health, safety, or welfare of the public; however, the action will provide an added safeguard for the public by clarifying for parents any monetary cost to them for their child's activities or programs at public school. Therefore, the proposed action is deemed necessary for the welfare of the public.

Substance: The proposed regulation provides changes to school board policies and procedures and includes specific provisions regarding permissible and impermissible fees, policies for families that cannot afford the fees, and impermissible actions for the failure to pay the fees.

The following changes related to policy are proposed:

1. Local school boards that charge fees would be required to have a policy and a fee schedule that would be provided to parents annually and posted on the school division's website.

2. The policy would include a provision to waive or reduce fees for economically disadvantaged students and students whose families are undergoing economic hardships.

3. The policy and fee schedule would be required to be consistent across the school division.

4. No fees could be charged that had not been approved by the local school division.

The following changes related to fees and charges are proposed:

1. Fees may not be charged as a condition of school enrollment unless the student is not of school age or does not live within the jurisdiction (§§ 22.1-1, 22.1-3, and 22.1-5 of the Code of Virginia).

2. Fees may not be charged for textbooks or textbook deposits; however, § 22.1-143 of the Code of Virginia permits local school divisions to assess a reasonable fee for lost or damaged textbooks.

3. Fees may not be charged for pupil transportation to and from school (Attorney General's Opinion dated August 29, 2007), but may be charged for the student's pro rata cost of

providing for voluntary extracurricular activities (§ 22.1-176 of the Code of Virginia).

4. Fees may be charged for summer school unless the summer school program is a remediation program required by the Standards of Quality (§ 22.1-253.13:1 of the Code of Virginia).

5. Fees may be charged for class dues; however, class dues shall not be mandatory, and the school board must specify the kinds of programs and activities covered by class dues.

6. Fees may be charged for nonmandatory services such as parking fees and locker fees (Attorney General's Opinions dated November 8, 1991 and 1964-65 Att'y Gen. Ann. Rep. 294).

7. Fees may be charged for consumable materials, such as workbooks, but the local school board must have a policy to ensure that these are furnished at a reduced price or free of charge to students who are unable to afford them (§ 22.1-243 of the Code of Virginia).

8. Fees may be charged for the behind the wheel portion of the driver's education program (§ 22.1-205 of the Code of Virginia).

9. Fees may be charged for the preparation and distribution of official paper copies of the student's transcript, provided that the school board first provides a reasonable number of copies for free. Official electronic copies of transcripts shall be provided at no cost.

The following additional provision related to nonpayment of fees is proposed:

A student may not be suspended or expelled for nonpayment of fees and charges.

Issues: While the Code of Virginia does not specifically require these regulations, it does limit the fees that may be charged to those that are permitted by state law or Board of Education regulations. Therefore, the Board of Education must adopt regulations in order to properly address the issue of what fees may or may not be charged by local school divisions. This proposal updates and clarifies an outdated regulation to provide better guidance to local school divisions and incorporates Attorney General's Opinions and changes to the Code of Virginia.

The proposed regulation provides changes to school board policies and procedures and includes specific provisions regarding permissible and impermissible fees, policies for families that cannot afford the fees, and permissible actions for the failure to pay the fees.

Some parents and members of the public have, over the years, believed that school divisions were not making provisions for low-income and disadvantaged families. This proposal is advantageous to students and their families who will have access to necessary information regarding fees and charges and who will be assured that fees charges by local school divisions are in accordance with state law and regulations. Additionally, the regulation will clarify that children from families that are economically disadvantaged will not be denied opportunities based on their inability to pay the imposed fees. There are no disadvantages to the public or the Commonwealth.

The Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The Rules Governing Fees and Charges, 8VAC20-370-10, were adopted on or before September 1, 1980, and have not been amended since that time. The Board of Education (Board) proposes to repeal these current regulations governing fees charged by local school divisions and create new provisions that would be added as a section to the proposed Regulations Governing Local School Boards and School Divisions, 8VAC20-720-10 et seq.

In addition to a different location within the Virginia Administrative Code, the proposed regulations governing fees charged by local school divisions would have the following changes: 1) Local school boards that charge fees would be required to have a policy and a fee schedule that would be provided to parents annually and posted on the school division's website. 2) The policy would include a provision to waive or reduce fees for economically disadvantaged students and students whose families are undergoing economic hardships. 3) The policy and fee schedule would be required to be consistent across the school division. 4) No fees could be charged that had not been approved by the local school division. 5) Fees may not be charged as a condition of school enrollment unless the student is not of school age or does not live within the jurisdiction (§§ 22.1-1, 22.1-3, and 22.1-5 of the Code of Virginia). 6) Fees may not be charged for textbooks or textbook deposits; however, § 22.1-243 of the Code of Virginia, permits local school divisions to assess a reasonable fee for lost or damaged textbooks. 7) Fees may not be charged for pupil transportation to and from school (Attorney General's Opinion dated August 29, 2007), but may be charged for the student's pro rata cost of providing for voluntary extracurricular activities (§ 22.1-176 of the Code of Virginia). 8) Fees may be charged for summer school unless the summer school program is a remediation program required by the Standards of Quality (§ 22.1-253.13:1 of the Code of Virginia). 9) Fees may be charged for class dues; however, class dues shall not be mandatory, and the school board must specify the kinds of programs and activities covered by class dues. 10) Fees may be charged for non-mandatory services such as parking fees and locker fees (Attorney General's Opinions dated November 8, 1991 and 1964-65 Att'y Gen. Ann. Rep. 294). 11) Fees may be charged for consumable materials, such as workbooks, but the local school board must have a policy to ensure that these are furnished at a reduced price or free of charge to students who

are unable to afford them (§ 22.1-243 of the Code of Virginia). 12) Fees may be charged for the behind the wheel portion of the driver's education program (§ 22.1-205 of the Code of Virginia). 13) Fees may be charged for the preparation and distribution of official paper copies of the student's transcript, provided that the school board first provides a reasonable number of copies for free. Official electronic copies of transcripts shall be provided at no cost. 14) A student may not be suspended or expelled for nonpayment of fees and charges.

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

Estimated Economic Impact. Much of the proposed amended language is beneficial in that helps provide clarity for the public. The clarifying language does not increase costs.

The Virginia Department of Education (Department) is not aware of how many school divisions currently post fee schedules on their websites. This is very useful information for parents and guardians. Since all divisions already have websites, the cost of posting this information is relatively small. Thus this proposal to require posting will create a net benefit for the Commonwealth.

The proposal to require that each school division provide for the reduction or waiver of fees for economically disadvantaged students and students whose families are undergoing economic hardships would reduce costs for some households. In 2008 the Department surveyed school divisions about fee policies. Of the 83 school divisions that responded to the survey in 2008, 64 school divisions answered that they assessed fees. Of these 64 divisions, 38 divisions answered that they had a schedule of fees and 20 responded that they had a financial hardship policy concerning fees. Thus it is likely that the proposed requirement to provide for the reduction or waiver of fees for economically disadvantaged students and students whose families are undergoing economic hardships will have a significant positive impact for some less well-to-do Virginia families.

Neither the Code of Virginia nor current regulations reference charges for the preparation and distribution of official paper copies of student transcripts. The Board proposes to specify that local school boards may charge fees for "the preparation and distribution of official paper copies of student transcripts; however, each school board shall provide a reasonable number of copies for free before a charge is levied for additional official copies. Official electronic copies of student transcripts shall be provided for free." The Department did not ask about transcript fees in their 2008 survey and are not currently aware of the distribution of fee policies for transcripts among local school divisions.

Businesses and Entities Affected. The proposed amendments affect the 132 school divisions in the Commonwealth as well as the over one million students in Virginia's public schools and their parents or guardians.

Localities Particularly Affected. The proposed amendments affect all localities and are not specifically known to disproportionately affect particular localities.

Projected Impact on Employment. The proposed amendments are unlikely to significantly affect employment.

Effects on the Use and Value of Private Property. The proposal to require that each school division provide for the reduction or waiver of fees for economically disadvantaged students and students whose families are undergoing economic hardships would reduce costs for some households.

Small Businesses: Costs and Other Effects. The proposed amendments are unlikely to significantly affect small businesses.

Small Businesses: Alternative Method that Minimizes Adverse Impact. The proposed amendments are unlikely to significantly affect small businesses.

Real Estate Development Costs. The proposed amendments are unlikely to significantly affect 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 agrees with the economic impact analysis done by Department of Planning and Budget. The agency will continue to examine

the economic and administrative impact of the regulations as they progress through the Administrative Process Act process.

Summary:

The Rules Governing Fees and Charges, 8VAC20-370-10, were adopted on or before September 1, 1980, and have not been amended since that time. The Board of Education proposes to repeal these current regulations governing fees charged by local school divisions and create new provisions that would be added as a section to the proposed Regulations Governing Local School Boards and School Divisions, 8VAC20-720.

In addition to a different location within the Virginia Administrative Code, the proposed regulations governing fees charged by local school divisions would have the following changes: (i) local school boards that charge fees would be required to have a policy and a fee schedule that would be provided to parents annually and posted on the school division's website; (ii) the policy would include a provision to waive or reduce fees for economically disadvantaged students and students whose families are undergoing economic hardships; (iii) the policy and fee schedule would be required to be consistent across the school division; and (iv) no fee could be charged that had not been approved by the local school division. Additionally, fees may not be charged (i) as a condition of school enrollment unless the student is not of school age or does not live within the jurisdiction; (ii) for textbooks or textbook deposits; however, local school divisions may assess a reasonable fee for lost or damaged textbooks; and (iii) for pupil transportation to and from school but may be charged for the student's pro rata cost of providing for voluntary extracurricular activities. However, fees may be charged for (i) summer school unless the summer school program is a remediation program required by the Standards of Quality; (ii) class dues; however, class dues shall not be mandatory and the school board must specify the kinds of programs and activities covered by class dues; (iii) consumable materials, such as workbooks, but the local school board must have a policy to ensure that these are furnished at a reduced price or free of charge to students who are unable to afford them; (iv) nonmandatory services such as parking and lockers; (v) the behind the wheel portion of the driver's education program; and (vi) the preparation and distribution of official paper copies of the student's transcript, provided that the school board first provides a reasonable number of copies for free and official electronic copies of transcripts at no cost. Also, a student may not be suspended or expelled for nonpayment of fees and charges.

CHAPTER 720
REGULATIONS GOVERNING LOCAL SCHOOL BOARDS AND SCHOOL DIVISIONS

8VAC20-720-10 through 8VAC20-720-70. (Reserved.)

8VAC20-720-80. Student fees and charges.

A. No fees or charges may be levied on any pupil by any school board unless authorized by the Board of Education or prescribed by the Code of Virginia.

B. Each local school board shall develop a policy in accordance with the requirements of the Standards of Quality, § 22.1-253.13:7 of the Code of Virginia, addressing any fees that are charged. The policy shall include the schedule of fees charged by the school division, provisions for reducing or waiving fees, and sanctions for nonpayment of fees. The policy and the fee schedule shall be provided to parents annually and posted on the school division's website.

C. The policy shall provide for the reduction or waiver of fees for economically disadvantaged students and students whose families are undergoing economic hardships. This shall include, but not be limited to, families receiving unemployment benefits and public assistance, including Temporary Assistance for Needy Families (TANF), food stamps, and Medicaid; foster families caring for children in foster care; and families that are homeless.

D. School divisions shall not charge any fees that have not been approved by the local school board.

E. The fee policy and the fee schedule shall be consistent throughout the school division, although there may be different fee schedules for elementary, middle, and high schools.

F. Local school boards shall not charge fees:

1. As a condition of school enrollment, except for students who are not of school-age or who do not reside within the jurisdiction, in accordance with §§ 22.1-1 and 22.1-3 of the Code of Virginia and as provided for in § 22.1-5 of the Code of Virginia;

2. For instructional programs and activities, or materials required for instruction, except as specified in subsection G of this section;

3. For textbooks or textbook deposits; however, § 22.1-243 of the Code of Virginia permits a local school board to assess a reasonable fee or charge for lost or damaged textbooks;

4. For pupil transportation to and from school; or

5. For summer school programs or other forms of remediation required by the Standards of Quality, § 22.1-253.13:1 of the Code of Virginia.

G. Local school boards may charge fees for the following:

1. Nonmandatory services, such as parking or locker rental;

2. Nonmandatory extracurricular activities;

3. Class dues; however, class dues shall not be mandatory, and the school board shall specify the kinds of programs and activities covered by class dues;

4. Field trips or educationally-related programs that are not required instructional activities;

5. Deposits for musical instruments not required for instructional activities;

6. Distance learning classes for enrichment and not necessary to meet the requirements for a diploma;

7. Summer school, unless the classes are required for remediation as prescribed by the Standards of Quality, § 22.1-253.13:1 of the Code of Virginia;

8. Overdue or lost or damaged library books;

9. Lost or damaged textbooks, in accordance with § 22.1-243 of the Code of Virginia; however, textbooks shall be provided free of charge;

10. Consumable materials such as workbooks, writing books, and drawing books; however, in accordance with § 22.1-243 of the Code of Virginia, the local school board shall develop a policy ensuring that workbooks, writing books, and drawing books are furnished to students who are unable to afford them at a reduced price or free of charge;

11. The behind-the-wheel portion of the driver's education program in accordance with § 22.1-205 of the Code of Virginia;

12. A student's pro rata share of the cost of providing transportation for voluntary extracurricular activities, in accordance with § 22.1-176 of the Code of Virginia; and

13. The preparation and distribution of official paper copies of student transcripts; however, each school board shall provide a reasonable number of copies for free before a charge is levied for additional official copies. Official electronic copies of student transcripts shall be provided for free.

H. Local school boards shall not:

1. Withhold any student's scholastic report card or diploma because of nonpayment of fees and charges, in accordance with § 22.1-6 of the Code of Virginia; or

2. Suspend or expel a student for nonpayment of fees and charges.

I. Nothing in this chapter shall be construed to prohibit the school board of any county, city, or town from making supplies, services, or materials available to pupils at cost.

J. These regulations do not address the operation of school stores or fund-raising activities where transactions are strictly voluntary.

8VAC20-720-90 through 8VAC20-720-170. (Reserved.)

VA.R. Doc. No. R09-1531; Filed May 5, 2010, 10:05 a.m.

Proposed Regulation

Titles of Regulations: **8VAC20-170. Regulations Governing Instructional Materials -- Selection and Utilization by Local School Boards (repealing 8VAC20-170-10).**

8VAC20-220. Regulations Governing Textbook Adoption State Level (repealing 8VAC20-220-10 through 8VAC20-220-70).

8VAC20-230. Regulations Governing Textbook Adoption Local Level (repealing 8VAC20-230-10 through 8VAC20-230-40).

8VAC20-270. Regulations Governing Textbook Fund Management and Handling on Local Level (repealing 8VAC20-270-10 through 8VAC20-270-130).

8VAC20-720. Regulations Governing Local School Boards and School Divisions (adding 8VAC20-720-10 through 8VAC20-720-170).

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

Public Hearing Information:

June 3, 2010 - 7 p.m. - Marion Senior High School, 848 Stage Street, Marion, VA

June 10, 2010 - 7 p.m. - T. C. Williams High School, 3330 King Street, Alexandria, VA

June 10, 2010 - 7 p.m. - Jolliff Middle School, 1021 Jolliff Road, Chesapeake, VA

June 10, 2010 - 7 p.m. - James River High School, 3700 James River Road, Midlothian, VA

Public Comment Deadline: July 26, 2010.

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

Basis: Section 22.1-16 of the Code of Virginia authorizes the Board of Education to adopt bylaws for its own governance and promulgate such regulations as may be necessary to carry out its powers and duties and the provisions of Title 22.1 of the Code of Virginia. Section 22.1-242 of the Code of Virginia, effective July 1, 2008, requires the Board of Education to adopt regulations governing (i) the purchase of textbooks approved by it for use in the public schools directly from the publishers by school boards and (ii) the distribution of such textbooks for the use by children attending public

schools in Virginia. Additionally, § 22.1-38 of the Code of Virginia permits local school boards to use textbooks not approved by the Board of Education so long as the school board selects the books in accordance with regulations promulgated by the board.

Purpose: The purpose of this proposal is to repeal four current regulations and add to the proposed Regulations Governing Local School Boards and School Divisions, 8VAC20-720, by creating sections governing instructional materials and textbooks. The current regulations governing instructional materials and textbooks will be repealed simultaneously with the adoption of the additions in this regulatory action to the proposed Regulations Governing Local School Boards and School Divisions. These proposed new sections will not become effective until after the proposed Regulations Governing Local School Boards and School Divisions become final.

The proposed regulation sections will capture the requirements of Chapters 430, 663, and 615 of the 2008 Acts of Assembly regarding textbook purchasing. These provisions relate to the approval of textbooks, basal textbooks, contacts with textbook publishers, and the selection of instructional materials by local school divisions. In addition, a number of provisions that are unnecessary, outdated, or are no longer required by the Code of Virginia are deleted. The goal of this proposal is to have regulations that comport with the Code of Virginia requirements governing textbooks and other statutes, such as the Virginia Procurement Act, while providing local school divisions and school boards more flexibility in the selection and purchasing of textbooks and instructional materials.

The proposed regulatory action will have no negative impact on the health, safety, or welfare of the public; however, the action will provide an added safeguard for the public by clarifying for parents their role in reviewing the textbooks under consideration for use in their child's classroom. Therefore, the proposed action is deemed necessary for the welfare of the public.

Substance: The proposed sections include provisions related to the approval of textbooks, basal textbooks, contracts with textbook publishers, the distribution of textbooks and consumable materials, and the selection of instructional materials by local school divisions. In addition, a number of provisions in the four sets of current regulations that are unnecessary, outdated, or are no longer required by the Code of Virginia are not included.

Issues: This proposal is beneficial to the public as well as local school divisions in that the provisions will be up-to-date and provide local school divisions with more flexibility without having a negative impact on the provision of educational services. The requirements regarding instructional materials and textbooks will be added to the proposed Regulations Governing Local School Boards and School Divisions once they are final. This will eliminate the need to consult four separate regulations making it easier for school divisions to determine applicable requirements. Additionally, the requirements regarding textbooks have been placed into one section and will provide the requirements for today's educational programs and more directly reflect current business practices.

The Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The Board of Education (Board) currently has three sets of regulations governing textbooks and one set of regulations governing instructional materials. The regulations governing textbooks are: Regulations Governing Textbook Adoption State Level (8VAC20-220), Regulations Governing Textbook Adoption Local Level (8VAC20-230), and Regulations Governing Textbook Fund Management and Handling on Local Level (8VAC20-270). The regulations governing instructional materials are: Regulations Governing Instructional Materials – Selection and Utilization by Local School Boards (8VAC20-170). All of these regulations were adopted on or before September 1, 1980, and have not been amended since that time. The Board proposes to repeal all four of these regulations and add provisions concerning textbooks and instructional materials to the proposed Regulations Governing Local School Boards and School Divisions (8VAC20-720).

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

Estimated Economic Impact. All of the proposed textbook and instructional material rules and requirements for the Regulations Governing Local School Boards and School Divisions are either essentially the same as the current rules and requirements in the existing four regulations mentioned above, reflect current federal law, are directly from the Code of Virginia, or are clarifications. Thus, the proposals will not have significant impact beyond the positive impact of additional clarity.

Businesses and Entities Affected. The proposed amendments affect the 132 school divisions in the Commonwealth as well as the over one million students in Virginia's public schools and their parents or guardians.

Localities Particularly Affected. The proposed amendments affect all localities and do not disproportionately affect particular localities.

Projected Impact on Employment. The proposed amendments are unlikely to significantly affect employment.

Effects on the Use and Value of Private Property. The proposed amendments are unlikely to significantly affect the use and value of private property.

Small Businesses: Costs and Other Effects. The proposed amendments are unlikely to significantly affect small businesses.

Small Businesses: Alternative Method that Minimizes Adverse Impact. The proposed amendments are unlikely to significantly affect small businesses.

Real Estate Development Costs. The proposed amendments are unlikely to significantly affect 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 agrees with the Economic Impact Analysis done by DPB. The agency will continue to examine the economic and administrative impact of the regulations as they progress through the Administrative Process Act process.

Summary:

The Board of Education currently has three sets of regulations governing textbooks and one set of regulations governing instructional materials. The regulations governing textbooks are: Regulations Governing Textbook Adoption State Level (8VAC20-220), Regulations Governing Textbook Adoption Local Level (8VAC20-230), and Regulations Governing Textbook Fund Management and Handling on Local Level (8VAC20-270). The regulations governing instructional materials are: Regulations Governing Instructional Materials – Selection and Utilization by Local School Boards (8VAC20-170). All of these regulations were adopted on or before September 1, 1980, and have not been amended since that time. The board proposes to repeal all four of these regulations and add provisions concerning textbooks and instructional materials to the proposed Regulations Governing Local School Boards and School Divisions (8VAC20-720). The proposed provisions relate to the approval of textbooks, basal textbooks, contracts with textbook publishers, and the selection of instructional materials by local school divisions.

CHAPTER 720
REGULATIONS GOVERNING LOCAL SCHOOL BOARDS AND SCHOOL DIVISIONS

8VAC20-720-10. Definitions.

"Textbooks" means print or electronic media for students use that serve as the primary curriculum basis for grade-level subject or course.

8VAC20-720-20 through 8VAC20-720-150. (Reserved.)

8VAC20-720-160. Instructional materials.

A. Local school boards shall be responsible for the selection, approval, and utilization of instructional materials.

B. Local school boards shall adopt policies and criteria for the selection of instructional materials that shall include, at a minimum:

1. Instituting a policy regarding the rights of parents to inspect, upon request, any instructional materials used as part of the educational curriculum for students, and the procedure for granting a request by a parent for such access, in accordance with the Protection of Pupil Rights Amendment, 20 USC § 123h, and its implementing regulation, 34 CFR Part 98;

2. Establishing procedures for the reconsideration of challenged materials;

3. Placing special emphasis on the thorough evaluation of materials related to controversial or sensitive topics such as sex education, moral education, and religion; and

4. Including in the curriculum and scheduling options for students whose parents choose to withdraw them from class for the duration of the treatment of a sensitive or controversial topic. Parents should be required to justify their requests.

8VAC20-720-170. Textbooks.

A. Textbook approval.

1. The Board of Education shall have the authority to approve textbooks for use in the public schools of Virginia.

2. In approving basal textbooks for reading in kindergarten and first grade, the board shall report to local school boards

those textbooks with a minimum decodability standard based on words that students can correctly read by properly attaching speech sounds to each letter to formulate the word at 70% or above for such textbooks, in accordance with § 22.1-239 of the Code of Virginia.

3. Any local school board may use textbooks not approved by the board provided the school board selects such books in accordance with this chapter.

B. Selection of textbooks by local school boards. Local school boards shall adopt procedures for the selection of textbooks. These procedures shall include, at a minimum, the following:

1. Appointment of an evaluation committee by the local school board to review and evaluate textbooks in one or more of the subject areas.

2. Notice to parents that textbooks under consideration for approval will be listed on the school division's website and made available at designated locations for review by any interested citizens. Provisions shall be made for those reviewing such textbooks to present their comments and observations, if any, to the school board through locally approved procedures. Actions that are necessary to assure appropriate consideration of citizen comments and observations shall be taken and adequate time for such consideration shall be allowed.

3. Use of selection criteria that has been approved by the local school board.

C. Purchasing Board of Education approved textbooks.

1. Local school divisions shall purchase textbooks approved by the Board of Education directly from the publishers of the textbooks by either entering into written term contracts or issuing purchase orders on an as-needed basis in accordance with § 22.1-241 of the Code of Virginia.

2. Such written comments or purchase orders shall be exempt from the Virginia Public Procurement Act (§ 2.2-4300 et seq. of the Code of Virginia) and from any local adopted regulations or procedures.

D. Purchasing non-Board of Education approved textbooks.

Local school divisions shall purchase non-Board of Education approved textbooks by either entering into written contracts or issuing purchase orders on an as-needed basis in accordance with locally adopted procurement procedures or regulations that contain requirements for competitive purchasing or the Virginia Public Procurement Act (§ 2.2-4300 et seq. of the Code of Virginia).

E. Certifications.

1. The division superintendent and chairperson of the local school board shall annually certify to the Virginia Department of Education that:

a. All textbooks were selected and purchased in accordance with this chapter; and

b. The price paid for each textbook was not in excess of that charged elsewhere in the United States in accordance with § 22.1-241 of the Code of Virginia.

2. The certification shall include a list of all textbooks adopted by the local school board.

VA.R. Doc. No. R08-1353; Filed May 5, 2010, 10:04 a.m.

TITLE 11. GAMING

VIRGINIA RACING COMMISSION

REGISTRAR'S NOTICE: The following regulatory actions filed by the Virginia Racing Commission are exempt from the Administrative Process Act pursuant to § 2.2-4002 A 18 of the Code of Virginia when promulgating regulations regulating actual live horse racing at race meetings licensed by the commission.

Proposed Regulation

Title of Regulation: **11VAC10-60. Participants (amending 11VAC10-60-70, 11VAC10-60-120).**

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

Effective Date: May 29, 2010.

Agency Contact: David S. Lermond, Jr., Regulatory Coordinator, Virginia Racing Commission, 10700 Horsemen's Lane, New Kent, VA 23024, telephone (804) 966-7404, FAX (804) 966-7418, or email david.lermond@vrc.virginia.gov.

Summary:

These amendments (i) clarify the consequences to a trainer who is suspended for more than 10 days in Virginia and (ii) reduce the amount of overweight a jockey may carry before a race from seven to five pounds.

11VAC10-60-70. Trainer.

A. Generally. No horse may be entered to race at a race meeting licensed by the commission unless the horse is under the care and supervision of a person holding a permit in good standing from the commission as a trainer. A trainer may represent the owner in entering of a horse, declaring the horse out of a race or retaining a jockey.

B. Qualifications. A permit may be issued to a person to participate in horse racing as a trainer if the person possesses a currently valid permit as a trainer in Virginia or another jurisdiction or if the person satisfactorily completes a trainer's test administered under the supervision of the stewards. A person shall not be issued a permit as a trainer unless he meets the following requirements:

1. The person must be 18 years old or older;

2. If the applicant for the permit is subject to the compensation provisions of the Virginia Workers' Compensation Act (§ 65.2-100 et seq. of the Code of Virginia), he must submit proof of his compliance with the insurance and self-insurance provisions of that Act with his application for the permit;

3. The person must be qualified by experience or competence to care for and train racehorses; and

4. The person must have in his charge a horse eligible to race.

C. Trainer's test. The stewards may require any person, whether or not he holds a currently valid permit in Virginia or another jurisdiction as a trainer, to satisfactorily complete a trainer's test to demonstrate that he is qualified by experience or competence to care for and train racehorses. The test shall consist of a written test administered by the stewards and a barn test administered by representatives of the horsemen, under the supervision of the stewards.

D. Prohibitions. A holder of a permit may not participate in horse racing as a trainer and as a jockey agent, veterinarian or veterinarian's assistant. In addition, a trainer:

1. Shall not train horses under an assumed name or stable name;

2. Shall not engage in any activity, directly or indirectly, involving the care, supervision or racing of horses other than those he has registered with the racing secretary as being in his charge; and

3. A holder of permits to participate in horse racing as a trainer and as a jockey shall only ride those horses trained by the permit holder.

E. Suspension. ~~All horses in the charge of a trainer whose permit is suspended for more than 10 days or revoked shall not be allowed to race. When a trainer's permit is suspended or revoked, it shall be the responsibility of the owners of the horses to designate in writing to the stewards to whom the responsibilities for training the horses shall be transferred. This written notice shall be presented to the stewards for approval. The stewards, in their discretion, may withhold approval of a transfer of horses to another trainer, if they believe that the transfer of the horses to another trainer would in any way circumvent the intent of the ruling of the commission.~~ All horses in the care of a trainer who is suspended for more than 10 days must be transferred to another trainer approved by the stewards. During the period of suspension the suspended trainer shall (i) have no communication with the new trainer, the new trainer's staff, or the horse owner; (ii) not benefit financially from transferred horses in his stable during the time of suspension; and (iii) not be permitted on the grounds except with the permission of the stewards.

F. Duties. A person holding a permit allowing him to participate in horse racing as a trainer shall be responsible for the proper care, health, training, safety and protection of horses under his care against administration of all substances foreign to the natural horse, except those specifically permitted by the regulations of the commission. In the exercise of his duties, a trainer shall:

1. Register with the stewards all persons in his employ and ensure that all of his employees have made application for the appropriate permits from the commission;

2. Promptly notify the stewards and the licensee's director of security of any employee he discharges;

3. Register all horses in his charge and present to the racing secretary the certificates of registration, certificates of eligibility or other registration documents;

4. Enter horses with the permission of the owner and bear primary responsibility as to the horse's eligibility, weight allowances, racing fitness, proper shoes, bandages, and other equipment;

5. Ensure that the horse is in the paddock at the time prescribed by the stewards;

6. Furnish the name of the jockey engaged to ride the horse at the time designated by the racing secretary;

7. Attend the horse in the paddock and supervise the saddling of the horse, and in his absence, provide an assistant trainer or other trainer to attend the saddling of horses and assume responsibility for the horses already entered;

8. Witness himself, or assign one of his employees to witness, the collection of samples of blood, urine, or other bodily substances in the test barn;

9. Maintain the stable area assigned to his horses in a neat, clean and sanitary condition at all times, and ensure that all fire prevention measures are taken; and

10. Report promptly to the commission veterinarian any serious illness or death of a horse in his charge.

G. Standardbred trainer. A permit may be issued to a person desiring to participate in horse racing as a trainer of Standardbreds if the person possesses a currently valid trainer's license from the United States Trotting Association or a permit in Virginia.

H. Steeplechase trainer. A permit may be issued to a person desiring to participate in horse racing as a trainer of horses utilized in steeplechase races if the person possesses a currently valid trainer's license issued by the stewards of the National Steeplechase Association or a currently valid permit as a trainer of horses utilized in steeplechase races in Virginia or another jurisdiction.

I. Substitute trainer. When a trainer is absent from his stable or the enclosure and a horse under his care is scheduled to race, he must provide a licensed trainer or assistant trainer to assume joint responsibility for the horses he is training. The substitute trainer or assistant trainer shall sign, in the presence of the stewards, a statement accepting responsibility for those horses.

J. Assistant trainer. A person holding a permit allowing him to participate in horse racing as a trainer may employ an assistant trainer with the approval of the stewards. Any assistant trainer shall be qualified to assume the duties and responsibilities imposed upon the holder of a trainer's permit, and the trainer shall be jointly responsible for the assistant trainer's acts and omissions involving racing matters and this chapter.

K. Trainer responsibility. The trainer shall be the absolute insurer of, and responsible for, the condition of each horse he enters in a race, regardless of the acts of third parties. A trainer shall not start a horse or permit a horse in his custody, care or control to be started if he knows, or through the exercise of reasonable care he might have known or has cause to believe, that the horse has received a substance foreign to the natural horse, except those specifically permitted by the regulations of the commission. The trainer shall guard, or caused to be guarded, each horse in his charge in a manner and for a period of time before racing so as to prevent any person from administering a substance foreign to the natural horse, except those specifically permitted by the regulations of the commission.

11VAC10-60-120. Jockey.

A. Generally. A person shall submit an application to participate in horse racing as a jockey. The applicant shall submit to the stewards sufficient evidence that he is either a journeyman or apprentice jockey in Virginia or another jurisdiction and demonstrates sufficient horsemanship to ride in a race without jeopardizing the safety of horses or other jockeys.

B. Examinations. A jockey may be required to take a physical examination from a physician appointed by the stewards to establish that he possesses the physical ability to safely ride in races. A jockey may also be required to take an eye examination from a physician appointed by the stewards to establish he has eyesight sufficient to safely ride in races.

C. Apprentice jockey. If the person does not possess a currently valid permit in Virginia or another jurisdiction as an apprentice jockey, has not ridden satisfactorily in three races at a pari-mutuel meeting, or has never held a thoroughbred journeyman jockey permit, then the stewards may allow the person to ride probationary mounts in three races at a race meeting licensed by the commission under the following conditions:

1. That he is at least 16 years old;

2. That he has held a permit for at least one year as an exercise rider under the supervision of a person holding a permit as a trainer;

3. A trainer submits a notarized statement to the stewards that the person has been employed by him and has demonstrated sufficient horsemanship to be allowed to ride in three races at a race meeting licensed by the commission;

4. The starter has schooled the person from the starting gate with other horses and approves the person as capable of breaking a horse properly from the starting gate;

5. The stewards retain sole discretion of whether or not the person possesses the physical ability and has demonstrated sufficient horsemanship to ride in a race without jeopardizing the safety of horses or other jockeys; and

6. The stewards, in their discretion, may at any time deny the person the opportunity to ride in more races for cause.

If the person possesses a currently valid permit from another jurisdiction as an apprentice jockey or has ridden satisfactorily in three races at a pari-mutuel meeting, then the person must submit sufficient evidence to the stewards:

a. That he is at least 16 years old;

b. That he has ridden satisfactorily in at least three races at a pari-mutuel meeting; and

c. That he has demonstrated to the stewards sufficient horsemanship to ride in a race without jeopardizing the safety of horses or other jockeys.

D. Amateur jockey. A permit may be issued to a person desiring to participate in horse racing as an amateur jockey. The person shall compete on even terms when riding against professional jockeys, but he shall not accept any fees or gratuities. The person must meet all of the requirements for an apprentice jockey, and his amateur status must be noted on the program.

E. Steeplechase jockey. A permit may be issued to a person desiring to participate in horse racing as a jockey riding horses in steeplechase races. A person shall submit an application for the appropriate permit, meet all of the requirements pertaining to holders of permits as jockeys, and hold a currently valid license issued by the stewards of the National Steeplechase Association.

F. Foreign jockey. Whenever a jockey from a foreign country, excluding Mexico and Canada, rides in the United States, he must submit an application for a permit and declare that he is a holder of a valid permit and currently not under suspension. To facilitate this process, the jockey shall present a declaration sheet stating:

1. That he is the holder of a valid permit to ride;

2. That he is not currently under suspension; and

3. That he agrees to be bound by the rules and regulations of the jurisdiction in which he is riding.

This sheet shall be retained by the stewards and at the conclusion of the jockey's participation in racing, it shall be returned to the jockey, properly endorsed by the stewards, stating he has not incurred any penalty or had a fall. If a penalty has been assessed against the jockey, the stewards shall notify the racing authority issuing the original permit to extend the penalty for the same period of time.

G. Apprentice allowance. An apprentice jockey may claim the following weight allowances in all overnight races except stakes and handicaps:

1. A 10-pound allowance beginning with the first mount and continuing until the apprentice has ridden five winners.

2. A seven-pound allowance until the apprentice has ridden an additional 35 winners.

3. If an apprentice has ridden a total of 40 winners prior to the end of a period of one year from the date of riding his fifth winner, he shall have an allowance of five pounds for one year from the date of the fifth winning mount.

4. If, after a period of one year from the date of the fifth winning mount, the apprentice jockey has not ridden 40 winners, the applicable weight allowance shall continue for one more year or until the apprentice rides his 40th winning mount, whichever comes first. But in no event may a weight allowance be claimed for more than two years from the date of the fifth winning mount, unless an extension has been granted under the provisions of this regulation.

5. An apprentice who possesses a contractual agreement may claim an allowance of three pounds for an additional one year when riding horses owned or trained by the original contract employer.

H. Extension of apprentice allowance. The commission or its designee may extend the weight allowance of an apprentice jockey when an apprentice jockey is unable to continue riding due to (i) physical disablement or illness, (ii) military service, (iii) attendance in an institution of secondary or higher education, (iv) restriction on racing, or (v) other valid reasons.

1. In order to qualify for an extension, an apprentice jockey shall have been rendered unable to ride for a period of not less than seven consecutive days during the period in which the apprentice was entitled to an apprentice weight allowance. Under exceptional circumstances, the commission or its designee will give consideration to the total days lost collectively.

2. The commission or its designee shall have the authority to grant an extension to an eligible applicant, but only after the apprentice jockey has submitted documentation to them verifying the days lost as defined by this regulation.

3. An apprentice jockey may petition the commission or its designee for an extension of time for claiming apprentice weight allowances, and the apprentice jockey shall be bound by the decision of the commission or its designee. If the apprentice jockey has been denied an extension in another jurisdiction, the commission or its designee shall deny the application for an extension.

I. Jockey contracts. An apprentice jockey may enter into a contract with an owner or trainer, who holds an appropriate permit issued by the commission, for a period not less than three years nor more than five years. The following provisions shall apply to contracts for apprentice jockeys:

1. The original contract is to be submitted to the stewards with copies made available to the parties to the contract;

2. A written extension may be made to a contract, if the original was for less than five years;

3. The original contract shall be kept in full force and in effect throughout its contract period. Any and all amendments to the contract shall be made a part of and either added to or attached to copies in the possession of the parties and a copy of the amendments submitted to the stewards;

4. An owner or trainer may not enter into a contract with an apprentice jockey unless he has control or possession of a stable of horses as would, in the discretion of the stewards, warrant the employment of an apprentice;

5. An apprentice jockey may not acquire his own contract;

6. All apprentice jockey contracts must be submitted to the stewards within 30 days of their execution or upon filing an application for a permit;

7. The contract shall provide for fair remuneration, adequate medical attention, suitable board and lodging, workers' compensation insurance coverage, and provision for conserving the savings out of the earnings of the apprentice; and

8. Any apprentice or contract rider shall be entitled to the regular jockey fees, except when riding a horse owned in part or solely by his contract holder. An interest in the

winnings only, e.g., a trainer's commission, does not constitute ownership.

J. Apprentice certificate. An apprentice jockey may be granted an apprentice certificate issued by the commission or its designee, in lieu of a traditional apprentice contract. An apprentice jockey who loses his weight allowances shall obtain a jockey permit before being permitted to ride again.

K. Restrictions of jockeys under contract. Any apprentice or journeyman jockey who is under a contract to an owner or trainer shall not:

1. Ride any horse not owned or trained by his contract employer in a race against a horse owned or trained by his contract employer;

2. Ride or agree to ride any horse in a race without consent of his contract employer; and

3. Share any money earned from riding with his contract employer.

L. Calls and engagements. Any jockey who is not prohibited by a contract may agree to give first or second calls on his services to any owner or trainer. If the agreement is for more than 30 days, then the agreement must be in writing and a copy of the agreement submitted to the stewards for approval. Any jockey employed by an owner or trainer on a regular salaried basis may not ride against the stable. No owner or trainer shall employ or engage a jockey to prevent him from riding another horse.

M. Naming of jockeys. A jockey shall be named to ride a horse in a race at a time designated by the racing secretary, and a subsequent change of a jockey shall be approved by the stewards. The following provisions shall apply to the naming of a jockey:

1. After a jockey gives a call to ride a horse in a race, either personally or through his agent, and fails to fulfill the engagement, he shall not accept another engagement in that race or be assigned by the stewards to another horse in that race;

2. In races where a jockey has more than one engagement, the jockey agent shall specify a first and second call on the jockey's services; and

3. A jockey may be named on no more than two horses in a race. In turf course races, in which there is an also-eligible list for the dirt course, a jockey may be named on no more than three horses, one of which shall be a dirt course only entrant.

N. Fee earned. A jockey's fee shall be considered earned when the jockey is weighed out by the clerk of scales. The fee shall not be considered earned if the jockey, of his own free will, takes himself off of his mount where injury to the horse or rider is not involved. Any conditions or considerations not covered by the above regulation shall be at the discretion of the stewards.

O. Multiple engagements. If any owner, or his trainer or authorized agent, engages two or more jockeys to ride the same horse in the same race after the time designated by the racing secretary to name jockeys, the owner shall pay the jockey taken off the horse a matching fee equal to that earned by the jockey who rode the horse. No owner shall be held liable for multiple engagements where such engagements are the results of actions taken by jockeys or their agents. An owner or trainer who elects to remove a jockey from his mount after the time designated by the racing secretary for naming jockeys may be subject to disciplinary action by the stewards.

P. Duty to fulfill engagements. A jockey shall fulfill his duly scheduled riding engagements, unless excused by the stewards. No jockey shall be forced to ride a horse he believes to be unsound or over a racing surface that he believes to be unsafe. If the stewards find that a jockey's refusal to fulfill a riding engagement is unwarranted, then the jockey may be subject to disciplinary action.

Q. Presence in jockey room. A jockey who has an engagement to ride in a race shall report his weight and be physically present in the jockeys' room at a time appointed by the stewards, unless excused by the stewards, and upon arrival shall report all of his engagements for the program to the clerk of scales. The following provisions shall apply:

1. In the event a jockey does not report to the clerk of scales at the appointed time, the clerk of scales shall advise the stewards who may name a substitute jockey and any substitution shall be publicly announced prior to the opening of wagering;

2. After reporting to the clerk of scales, a jockey shall remain in the jockeys' room until he has fulfilled all of his engagements for the program. A jockey may only leave to ride in a race or to view the races from a location approved by the stewards;

3. A jockey shall have no communication with any person outside the jockeys' room other than an owner or trainer for whom he is riding, a racing official, his jockey agent or a representative of the media; and

4. A jockey who intends to discontinue riding at a race meeting prior to its conclusion shall notify the stewards no later than upon fulfilling his final engagement of the day he intends to depart.

R. Attire. A jockey shall wear traditional attire and shall be neat and clean in appearance. A jockey shall wear the cap and jacket in the owner's racing colors, white breeches, top boots, protective helmet, safety vest which meets the minimum specifications as defined by the British Equestrian Trade Association, and a number on his right shoulder

corresponding to the horse's number as shown on the saddle cloth and daily program.

S. Weighing out. A jockey shall report to the clerk of scales for weighing out, not more than one hour and not less than 15 minutes before post time for each race in which he is engaged to ride, and at the time of weighing out shall declare overweight, if any. The following provisions shall apply to weighing out:

1. A jockey shall not carry more than two pounds of overweight without the consent of the owner or trainer of the horse which he is engaged to ride; however, a jockey shall not carry more than ~~seven~~ five pounds of overweight;

2. Bit, blinkers, bridle, number cloth, reins, safety helmet, safety vest, whip, goggles, overgirth, chamois and breastplate shall not be included in a jockey's weight;

3. All overweights shall be promptly reported to the stewards; and

4. No horse shall be disqualified because of overweight carried.

T. Weighing in. Following the completion of the race, a jockey shall ride his horse to the designated area, salute the stewards, dismount, remove from the horse his equipment, without assistance, which is to be included in a jockey's weight, and move directly to the scales where he may be weighed in by the clerk of scales. No person shall throw any covering over any horse until a jockey has removed from the horse his equipment which is to be included in a jockey's weight. Due to injury to either horse or jockey, the stewards may excuse the jockey from weighing in. A jockey shall not weigh in at less weight than he weighed out and no jockey shall weigh in at more than four pounds over the weight at which he weighed out, unless affected by the weather and with the permission of the stewards.

U. Wagering. A jockey may only have a wager placed for him through an owner or trainer of the horse he is riding in the race, and the jockey's wager shall only be on his horse to win. The owner or trainer placing the wager shall keep precise records of all wagers placed for a jockey and the record shall be available to the stewards upon request.

V. Viewing films. The stewards shall attempt to notify all jockeys who are requested to attend the reviewing of the films, and their names shall be posted on the film list. A jockey whose name is on the film list shall be present at the designated time and place to view the films of the race, unless excused by the stewards. A jockey may be accompanied by a representative of his choosing.

W. Designated races. A jockey who is serving a suspension of 10 days or less will be permitted to ride in a designated race during the suspension if:

1. The race has been specified as a designated race by the racing secretary before opening day of the race meeting.

2. The race has been approved as a designated race by the stewards.

3. The jockey is named not later than at the time designated by the racing secretary.

4. The jockey agrees to serve an additional day of suspension in place of the day on which the jockey rides in a designated race.

Reciprocity of this regulation will apply only to those jurisdictions which have adopted the designated race regulation.

VA.R. Doc. No. R10-2347; Filed May 5, 2010, 11:47 a.m.

Proposed Regulation

Title of Regulation: **11VAC10-110. Entries (amending 11VAC10-110-100, 11VAC10-110-180, 11VAC10-110-190).**

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

Effective Date: May 29, 2010.

Agency Contact: David S. Lermond, Jr., Regulatory Coordinator, Virginia Racing Commission, 10700 Horsemen's Lane, New Kent, VA 23024, telephone (804) 966-7404, FAX (804) 966-7418, or email david.lermond@vrc.virginia.gov.

Summary:

The proposed amendments (i) clarify that the responsibility of claiming weight penalties and weight allowances as well as the eligibility of a horse rests solely with the trainer and (ii) simplify the rule for how long a horse must wait before racing again after being excused by the stewards or a veterinarian.

11VAC10-110-100. Penalties and allowances.

The ~~primary~~ responsibility for claiming the weight penalties and weight allowances ~~for thoroughbreds and quarter horses~~ shall rest with the ~~person filing the entry~~ trainer. ~~However, the racing secretary shall be secondarily responsible for verifying the correctness of the penalties and allowances claimed by the nominator.~~ The following provisions shall apply to penalties and allowances:

1. Penalties are obligatory;

2. Allowances are optional as to all of the allowance or any part thereof;

3. Allowances must be claimed at the time of entry and cannot be waived after the closing of entries, except by permission of the stewards;

4. A horse shall start with only the allowance of weight to which it is entitled at the time of starting, regardless of the allowance it was entitled to at the time of entry;

5. Horses incurring penalties for a race shall not be entitled to any allowances, with the exception of age, sex or apprentice, for that race;

6. An apprentice allowance may be claimed only in overnight races and cannot be claimed in a stakes or handicap race;

7. Horses not entitled to the first allowance in a race shall not be entitled to any subsequent allowance specified in the conditions;

8. Allowances are not cumulative, unless specified in the conditions of the race;

9. Failure to claim an allowance is not cause for disqualifying the horse;

10. A claim of an allowance to which a horse is not entitled shall not disqualify the horse unless the incorrect weight is carried by the horse in the race;

11. A protest that a claim of an allowance is incorrect must be made in writing and submitted to the stewards at least one hour before post time;

12. No horse shall incur a penalty or be barred from any race for having finished second or lower in any race;

13. No horse shall be given a weight allowance for failure to finish second or lower in any race;

14. No horse shall receive an allowance for not winning in one or more races, but maiden allowances and allowances to horses that have not won a race within a specified period or a race of a specified value are permissible;

15. Penalties incurred and allowances due in jump races shall not apply to races on the flat and vice versa;

16. No horse shall incur a penalty for a placing from which it was subsequently disqualified, but a horse earning a placing through the disqualification shall incur the penalty for that placement;

17. When a race is under appeal, the horse that finished first and any other horse, which may be moved into first place, shall be liable for all penalties attached to the winner until there has been a final determination;

18. Any error discovered in the assignment of any penalty or claim of any allowance may be corrected, with the permission of the stewards, until 45 minutes prior to post time;

19. In determining eligibility, allowances and penalties, the reports, records and statistics as published in the Daily Racing Form and its monthly chart books or any similar publication shall be considered official; and

20. In all races, except handicaps and races where the conditions expressly state otherwise, two-year-old fillies are allowed three pounds and fillies and mares three years old and upward are allowed five pounds before September 1 and three pounds thereafter.

11VAC10-110-180. Scratches.

For flat racing, a horse may be withdrawn from or "scratched out" of a race after the closing of entries under the following conditions:

1. Scratches shall be made in a manner prescribed by the racing secretary;

2. Scratches are subject to the approval of the stewards;

3. A horse may be scratched from a stakes race, futurity or other special event until 45 minutes before post time for the race for any reason;

4. No horse may be scratched from an overnight race without the approval of the stewards;

5. In making a determination on whether to permit a horse to be scratched from an overnight race, the stewards may require a report from a veterinarian, who possesses a permit issued by the commission, attesting to the physical condition of the horse;

6. Scratches, once approved by the stewards, are irrevocable; and

7. ~~Entry of any~~ Any horse that has been scratched or excused from starting by the stewards because of a physical disability or sickness shall not be ~~accepted~~ permitted to race again until the horse has been removed from the Veterinarian's List by the commission veterinarian and the expiration of ~~three racing~~ six calendar days ~~after~~ following the day on which such horse was scratched or excused ~~and the horse has been removed from the Veterinarian's List by the commission veterinarian~~.

11VAC10-110-190. Responsibility for eligibility.

The ~~primary~~ responsibility for the eligibility of a horse for a race shall rest with the ~~person filing the entry~~ trainer. ~~In any event, a~~ No person shall ~~not~~ enter a horse ~~which~~ that is ineligible under the conditions specified in the condition book or condition sheet. ~~The racing secretary shall be secondarily responsible for verifying the eligibility of each horse as specified in the condition book or condition sheet as well as the penalties and allowances.~~

VA.R. Doc. No. R10-2348; Filed May 5, 2010, 11:46 a.m.

Proposed Regulation

Title of Regulation: **11VAC10-140. Flat Racing (amending 11VAC10-140-40, 11VAC10-140-60).**

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

Effective Date: May 29, 2010.

Agency Contact: David S. Lermond, Jr., Regulatory Coordinator, Virginia Racing Commission, 10700 Horsemen's Lane, New Kent, VA 23024, telephone (804) 966-7404, FAX (804) 966-7418, or email david.lermond@vrc.virginia.gov.

Summary:

The amendments (i) clarify that the commission veterinarian or his designee is permitted to touch a horse while in the paddock and (ii) require the permission of the stewards to add or discontinue the use of equipment that restricts vision or affects performance.

11VAC10-140-40. Prohibitions.

No person other than the horse's owner, trainer, employees of the owner or trainer, paddock judge, horse identifier, assigned valet, commission veterinarian or his designee, steward, farrier, pony rider, or outrider shall touch a horse while it is in the paddock. The material used as a tongue tie shall be supplied by the horse's trainer or his designee, who shall affix the tongue tie in the paddock.

11VAC10-140-60. Changing equipment.

Permission must be obtained from the stewards for the following changes of a horse's equipment from that which the horse used in its last previous start:

1. To add blinkers or any device that would restrict vision or could affect performance to a horse's equipment or to discontinue the use of blinkers or any such device that would restrict vision or could affect performance;

2. To use or discontinue use of a bar plate;

3. To race a horse without shoes or with a type of shoes not generally used for racing; and

4. To race a horse without the jockey carrying a whip.

Changes of equipment shall be noted in the daily program. In the absence of such notation, the change of equipment shall be announced to the public and noted on the closed-circuit television system. The stewards shall cause an appropriate public announcement or a display to be made in the paddock or elsewhere at the discretion of the stewards for the aforementioned changes of equipment.

VA.R. Doc. No. R10-2349; Filed May 5, 2010, 11:47 a.m.

Final Regulation

REGISTRAR'S NOTICE: The Virginia Racing Commission is exempt from the Administrative Process Act pursuant to § 2.2-4002 B 23 of the Code of Virginia when promulgating regulations pertaining to the administration of medication or other substances foreign to the natural horse.

Title of Regulation: **11VAC10-180. Medication (amending 11VAC10-180-35, 11VAC10-180-60, 11VAC10-180-75, 11VAC10-180-90, 11VAC10-180-100, 11VAC10-180-110).**

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

Effective Date: May 29, 2010.

Agency Contact: David S. Lermond, Jr., Regulatory Coordinator, Virginia Racing Commission, 10700 Horsemen's Lane, New Kent, VA 23024, telephone (804) 966-7404, FAX (804) 966-7418, or email david.lermond@vrc.virginia.gov.

Summary:

The amendments add rules pertaining to intra-articular injections, peri-neural injections, and hyperbaric oxygen chambers. Also, a recommended penalty for category "D" drug violations has been added. In addition, these amendments clarify what the consequences will be to a trainer who is suspended for more than 10 days in Virginia to correspond with an amendment being made to 11VAC10-60, Participants. Finally, these amendments include minor changes to rules concerning steroids, test barn procedures, reporting procedures, and split samples. These amendments were recommended to the commission by the Virginia Racing Commission's Equine Medical Director and Code Revision and Rules Committee.

11VAC10-180-35. Prohibited practices.

A. No trainer shall allow a horse to appear in a race, qualifying race or official timed workout, when the horse contains in its system any prohibited substance, as determined by testing of blood, saliva or urine, or any other reasonable means.

B. No person shall administer any substance to a horse on race day other than those substances expressly permitted by the commission. Substances permitted by the commission shall be administered solely for the benefit and welfare of the horse, nonperformance altering, of no danger to riders/drivers, and unlikely to interfere with the detection of prohibited substances.

C. No veterinarian or permit holder shall, without good cause, possess or administer any substance to a horse stabled within the enclosure or at any facility under the jurisdiction of the commission:

1. That has not been approved by the U.S. Food and Drug Administration (FDA) for any use (human or animal), or the U.S. Department of Agriculture's Center for Veterinary Biologics;

2. That is on the U.S. Drug Enforcement Agency's Schedule I or Schedule II of controlled substances as prepared by the Attorney General of the United States pursuant to 21 USC § 811 and 812;

3. That its use may endanger the health and welfare of the horse or endanger the safety of the rider or driver, or its use may adversely affect the integrity of racing; or

4. That does not have a recognized laboratory analytical method to detect and confirm its administration.

D. No person, except a veterinarian holding a valid veterinarian's permit or an assistant under his immediate supervision, shall have in his possession within the enclosure of a horse racing facility any prescription substance for animal use unless:

1. The person actually possesses, within the enclosure of the horse racing facility, documentary evidence that a prescription has been issued to him for the substance by a licensed veterinarian;

2. The prescription substance is labeled with a dosage for the horse or horses to be treated with the prescription substance; and

3. The horse or horses named in the prescription are then under the care and supervision of the permit holder and are then stabled within the enclosure of the horse racing facility.

E. The possession or administration of erythropoietin (Epogen), darbepoietin, oxyglobin, Hemopure, or any analogous substance that increases oxygen-carrying capacity of the blood is prohibited. Furthermore, should the analysis of a test sample detect the presence of antibodies of erythropoietin or darbepoietin or any analogous substance in the horse's blood that indicates a history of use of these substances, the horse shall be prohibited from racing and placed on the veterinarian's list until the horse tests negative for the presence of such antibodies.

F. The use of androgenic and anabolic steroids is prohibited in racing horses as stipulated in 11VAC10-180-75.

G. The use of an extracorporal shockwave therapy device or radial pulse wave therapy device is prohibited on the racetrack premises and at any site that falls under the jurisdiction of the Virginia Racing Commission unless:

1. The therapy device is registered with the commission veterinarian;

2. The therapy device is used by a veterinarian who is a permit holder; and

3. Each use of the therapy device is reported to the commission veterinarian on the treatment report.

Notwithstanding the provisions above, whether on or off the premises, a shockwave therapy device or radial pulse wave therapy device shall not be used on a racehorse fewer than 10 days before the horse is to race. For the purposes of this calculation, the day of treatment shall be considered day one.

H. Tubing of horses prohibited. The tubing or dosing of any horse for any reason on race day is prohibited, unless administered for medical emergency purposes by a licensed veterinarian in which case the horse shall be scratched. The practice of administration of any substance, via a tube or other method, into a horse's stomach on race day is considered a violation of this chapter.

1. Using or possessing the ingredients or the paraphernalia associated with forced feeding to a horse of any alkalinizing agent with or without a concentrated form of carbohydrate, or administering any substance by tubing or other method on race day shall be considered a violation of this chapter.

2. Under the provisions of this subsection, endoscopic examination shall not be considered a violation of this chapter.

I. Notwithstanding any other provision in this chapter, no substance of any kind may be administered to a horse within three hours of the scheduled post time for the race in which the horse is entered. To ensure uniform supervision and conformity to this regulation, the trainer shall have each horse programmed to race stabled in its assigned stall within the enclosure of the horse race facility no fewer than four hours prior to post time for the respective race.

J. Intra-articular injections prohibited. Injecting any substance or inserting a needle into a joint space is prohibited within five days prior to the horse's race.

K. Peri-neural injections prohibited. Injecting a local anesthetic or other chemical agent adjacent to a nerve is prohibited within three days prior to the horse's race.

L. Hyperbaric oxygen chamber prohibited. Subjecting a horse to therapy utilizing a hyperbaric oxygen chamber is prohibited within four days prior to the horse's race.

11VAC10-180-60. Medications and prohibited substances.

A. Medications and prohibited substances are divided into five classes. The classes are:

1. Class 1. Substances found in this class have no generally accepted medical use in the racehorse and have a very high pharmacological potential for altering the performance of a racehorse. These substances should never be found in the horse's system through ~~post-race~~ postrace testing or in the possession of any holder of a permit within the enclosure of a horse racing facility licensed by the commission. Such substances are potent stimulants of the nervous system including opiates, opium derivatives, synthetic opioids, psychoactive drugs, amphetamines and U.S. Drug Enforcement Agency (DEA) Scheduled I and II controlled substances.

2. Class 2. Substances in this class have a high potential to affect the outcome of a race. Most are not generally

accepted as therapeutic agents in the racehorse. Many are products intended to alter consciousness or the psychic state of humans, and have no approved or indicated use in the horse. Some, such as injectable local anesthetics, have legitimate uses in equine medicine, but should not be found in a racehorse through postrace testing. The following groups of substances are in this class:

a. Opiate partial agonists or agonist-antagonists;

b. Nonopiate psychotropic drugs, which may have stimulant, depressant, analgesic or neuroleptic effects;

c. Miscellaneous substances that might have a stimulant effect on the central nervous system (CNS);

d. Drugs with prominent CNS depressant action;

e. Antidepressant and antipsychotic drugs, with or without prominent CNS stimulatory or depressant effects;

f. Muscle-blocking substances that have a direct neuromuscular blocking action;

g. Local anesthetics that have a reasonable potential for use as nerve-blocking agents (except procaine);

h. Other biological substances and snake venoms or chemicals that may be used as nerve-blocking agents; and

i. Erythropoietin (Epogen), darbepoietin, oxyglobin, hemopure, or other blood-doping agents.

3. Class 3. Substances found in this class may or may not have an accepted therapeutic use in the horse, but have a potential to enhance performance, and their presence in the horse's system is prohibited on race day. The following groups of substances are in this class:

a. Substances affecting the autonomic nervous system that do not have prominent CNS effects, but that do have prominent cardiovascular and respiratory system effects (bronchodilators are included in this category);

b. Local anesthetics that have nerve-blocking potential but also a high potential for producing urine residue levels from a method of use not related to the anesthetic effect of the substance (procaine);

c. Miscellaneous substances with mild sedative action, such as the sleep-inducing antihistamines;

d. Primary vasodilating/hypotensive agents;

e. Potent diuretics affecting renal function and body fluid composition; and

f. Anabolic and/or androgenic steroids and/or growth hormones ~~not specifically permitted by the regulations of the Virginia Racing Commission for use in racing horses~~ other than boldenone, stanozolol, nandrolone, and testosterone, which are classified elsewhere in this section.

4. Class 4. Substances in this class are primarily therapeutic medications routinely used in racehorses. These may influence performance, but generally have a more limited ability to do so. The following groups of drugs are in this class:

a. Nonopiate substances that have a mild central analgesic effect;

b. Substances affecting the autonomic nervous system that do not have prominent CNS, cardiovascular or respiratory effects:

(1) Substances used solely as topical vasoconstrictors or decongestants;

(2) Substances used as gastrointestinal antispasmodics;

(3) Substances used to void the urinary bladder; and

(4) Substances with a major effect on CNS vasculature or smooth muscle of visceral organs.

(5) Antihistamines that do not have a significant CNS depressant effect (this does not include H1 blocking agents, which are listed in Class 5).

c. Mineral corticoid substances;

d. Skeletal muscle relaxants;

e. Anti-inflammatory substances that may reduce pains as a consequence of their anti-inflammatory actions, which include:

(1) Nonsteroidal anti-inflammatory drugs (NSAIDs);

(2) Corticosteroids (glucocorticoids); and

(3) Miscellaneous anti-inflammatory agents.

f. Boldenone, stanozolol, nandrolone, and testosterone, individually but not in combination, at levels stipulated in 11VAC10-180-75.

g. Less potent diuretics;

h. Cardiac glycosides and antiarrhythmics including:

(1) Cardiac glycosides;

(2) Anti-arrhythmic agents (exclusive of lidocaine, bretylium and propranolol); and

(3) Miscellaneous cardiotonic drugs.

i. Topical anesthetics agents not available in injectable formulations;

j. Antidiarrheal agents; and

k. Miscellaneous substances including:

(1) Expectorants with little or no other pharmacologic action;

(2) Stomachics; and

(3) Mucolytic agents.

5. Class 5. Drugs in this class are therapeutic medications for which concentration limits have been established as well as certain miscellaneous agents. Included specifically are agents that have very localized action only, such as anti-ulcer drugs and certain anti-allergenic drugs. The anticoagulant drugs are also included.

B. Disciplinary actions.

1. In issuing penalties against individuals found guilty of medication and drug violations a regulatory distinction shall be made between the detection of therapeutic medications used routinely to treat racehorses and those drugs that have no reason to be found at any concentration in the test sample on race day.

2. The stewards or the commission will use the Racing Medication and Testing Consortium's penalty category and schedule as a starting place in the penalty stage of the deliberations for a rule violation for any drug listed in the Association of Racing Commissioners International (RCI) Uniform Classification Guidelines for Foreign Substances, revised July 2007.

3. If a licensed veterinarian is administering or prescribing a drug not listed in the RCI Uniform Classification Guidelines for Foreign Substances or shown in the RMTC penalty guideline listing, the identity of the drug shall be forwarded to the commission veterinarian to be forwarded to the Racing Medication and Testing Consortium for classification.

4. Any drug or metabolite thereof found to be present in a pre- or postrace sample that is not classified in the most current RCI Uniform Classification Guidelines for Foreign Substances shall be assumed to be an RCI Class 1 Drug and the trainer and owner shall be subject to those penalties as set forth in schedule "A" unless satisfactorily demonstrated otherwise by the Racing Medication and Testing Consortium, with a penalty category assigned.

5. The penalty categories and their related schedules, if applicable, shall be on the following criteria:

a. Whether the drug is approved by the U.S. Food and Drug Administration for use in the horse;

b. Whether the drug is approved by the U.S. Food and Drug Administration for use in any species;

c. Whether the drug has any legitimate therapeutic application in the equine athlete;

d. Whether the drug was identified as "necessary" by the RMTC Veterinary Advisory Committee;

e. Whether legitimate, recognized therapeutic alternatives exist; and

f. The current RCI classification of the drug.

6. Except as may be expressly stipulated in the regulations elsewhere, the penalty categories "A," "B," ~~and~~ "C," and "D" and their related schedules for trainers and owners are as follows:

a. The recommended penalties for violations due to the presence of a substance carrying a category "A" penalty and for violations of 11VAC10-180-35 are:

(1) First offense for the trainer will be:

(a) Minimum one-year suspension absent mitigating circumstances. The presence of aggravating factors could be used to impose a maximum of a five-year suspension;

(b) Minimum fine of $10,000 absent mitigating circumstances; and

(c) May be referred to the commission for any further action deemed necessary by the commission.

(2) Second lifetime offense in any jurisdiction for the trainer will be:

(a) Minimum five-year suspension absent mitigating circumstances. The presence of aggravating factors could be used to impose a maximum of license revocation with no reapplication for a five-year period;

(b) Minimum fine of $10,000 absent mitigating circumstances; and

(c) May be referred to the commission for any further action deemed necessary by the commission.

(3) Third and any subsequent lifetime offense in any jurisdiction for the trainer will be:

(a) Minimum 10-year suspension absent mitigating circumstances. The presence of aggravating factors could be used to impose a maximum of license revocation with no reapplication for a five-year period;

(b) Minimum fine of $10,000 absent mitigating circumstances; and

(c) May be referred to the commission for any further action deemed necessary by the commission.

(4) First offense for the owner will be:

(a) Disqualification and loss of purse; and

(b) Horse shall be placed on the veterinarian's list for 90 days and must pass a commission-approved examination before becoming eligible to be entered.

(5) Second lifetime offense in owner's stable in any jurisdiction will be:

(a) Disqualification, loss of purse and $5,000 fine; and

(b) Horse shall be placed on the veterinarian's list for 120 days and must pass a commission-approved examination before becoming eligible to be entered.

(6) Third and any subsequent lifetime offense in the owner's stable in any jurisdiction will be:

(a) Disqualification, loss of purse, $10,000 fine and 90 days suspension; and

(b) Horse shall be placed on the veterinarian's list for 180 days and must pass a commission-approved examination before becoming eligible to be entered.

b. The recommended penalties for violations due to the presence of a substance carrying a category "B" penalty, for the presence of more than one NSAID in a plasma or serum sample, and for violations of the established level for total carbon dioxide are:

(1) First offense for the trainer will be:

(a) Minimum 15-day suspension absent mitigating circumstances. The presence of aggravating factors could be used to impose a maximum of a 60-day suspension; and

(b) Minimum fine of $2,500 absent mitigating circumstances. The presence of aggravating factors could be sued to impose a maximum fine of $10,000.

(2) Second offense within a 365-day period in any jurisdiction for the trainer will be:

(a) Minimum 30-day suspension absent mitigating circumstances. The presence of aggravating factors could be used to impose a maximum of a 180-day suspension; and

(b) Minimum fine of $5,000 absent mitigating circumstances. The presence of aggravating factors could be used to impose a maximum fine of $10,000.

(3) Third and any subsequent offense within a 365-day period in any jurisdiction for the trainer will be:

(a) Minimum 90-day suspension absent mitigating circumstances. The presence of aggravating factors could be used to impose up to a maximum of a two-year suspension;

(b) Minimum fine of $10,000 absent mitigating circumstances; and

(c) May be referred to the commission for any further action deemed necessary by the commission.

(4) First offense for the owner will be:

(a) Disqualification and loss of purse; and

(b) Horse must pass a commission-approved examination before becoming eligible to be entered.

(5) Second offense in the owner's stable within a 365-day period in any jurisdiction will be:

(a) Disqualification and loss of purse; and

(b) Horse must pass a commission-approved examination before becoming eligible to be entered.

(6) Third and any subsequent offense in owner's stable within a 365-day period in any jurisdiction will be:

(a) Disqualification and loss of purse;

(b) Minimum fine of $5,000 absent mitigating circumstances; and

(c) Horse shall be placed on the veterinarian's list for 45 days and must pass a commission-approved examination before becoming eligible to be entered.

c. The recommended penalties for violations due to the presence of a substance carrying a category "C" penalty are:

(1) First offense for the trainer will be:

(a) Disqualification and loss of purse; and

(b) Minimum fine of $500 absent mitigating circumstances.

(2) Second offense for the trainer within a 365-day period in any jurisdiction will be:

(a) Disqualification and loss of purse;

(b) Minimum fine of $1,000 absent mitigating circumstances; and

(c) Minimum 15-day suspension absent mitigating circumstances.

(3) Third and any subsequent offense for the trainer within a 365-day period in any jurisdiction will be:

(a) Disqualification and loss of purse;

(b) Minimum fine of $2,500 absent mitigating circumstances; and

(c) Minimum 30-day suspension absent mitigating circumstances.

(4) First offense for the owner will be:

(a) Disqualification and loss of purse;

(b) Horse must pass a commission-approved examination before becoming eligible to be entered.

(5) Second offense in owner's stable within a 365-day period in any jurisdiction will be:

(a) Disqualification and loss of purse;

(b) Horse shall be placed on the veterinarian's list for 45 days and must pass a commission-approved examination before becoming eligible to be entered.

(6) Third and any subsequent offense in owner's stable within a 365-day period in any jurisdiction will be:

(a) Disqualification and loss of purse;

(b) Minimum fine of $5,000 absent mitigating circumstances; and

(c) Horse shall be placed on the veterinarian's list for 60 days and must pass a commission-approved examination before becoming eligible to be entered.

d. The recommended penalty for violations due to the presence of a substance carrying a category "D" penalty is an official letter of reprimand.

7. Any permit holder of the commission, including practicing veterinarians, found to be responsible for the improper or intentional administration of any drug resulting in a positive test may be subject to the same penalties set forth to the trainer.

8. Any veterinarian found to be involved in the administration of any drug carrying the penalty category of "A" shall be referred to the respective state licensing board of veterinary medicine for consideration of further disciplinary action and/or license revocation. This is in addition to any penalties issued by the stewards or the commission.

9. Any person who the stewards or the commission believe may have committed acts in violation of criminal statutes shall be referred to the appropriate law-enforcement agency. Administrative action taken by the stewards or the commission in no way prohibits a prosecution for criminal acts committed, nor does a potential criminal prosecution stall administrative action by the stewards or the commission.

10. Pursuant to 11VAC10-60-70 E of the commission regulations, ~~horses in the care of a trainer who is suspended for 10 days or more must be transferred to another trainer approved by the stewards. During the period of suspension the suspended trainer shall have no communication, oral or written, with the new trainer and shall not benefit financially from horses in his stable at the time of suspension.~~ all horses in the care of a trainer who is suspended for more than 10 days must be transferred to another trainer approved by the stewards. During the period of suspension the suspended trainer shall have no communication with the new trainer, the new trainers' staff, or the horse owner; shall not benefit financially from transferred horses in his stable during the time of suspension; and shall not be permitted on the grounds except with the permission of the stewards.

11VAC10-180-75. Androgenic and anabolic ~~steriods~~ steroids.

A. All androgenic and anabolic steroids are prohibited in racing horses, except as provided below.

B. Residues of the major metabolite of stanozolol, nandrolone, boldenone and testosterone at concentrations less than the thresholds indicated below are permitted in test samples collected from racing horses.

C. Concentrations of these substances identified in subsection B of this section shall not exceed the following total threshold concentrations (i.e., free drug or metabolite and drug or metabolite liberated from its conjugates):

1. Metabolite of stanozolol (16Beta-hydroxystanozolol) – 1 ng/ml in urine for all horses regardless of gender.

2. Boldenone – 15 ng/ml in urine in male horses other than geldings. No boldenone is permitted in geldings or female horses.

3. Nandrolone:

a. 1 ng/ml in urine in geldings, fillies, and mares.

b. 45 ng/ml in urine in male horses other than geldings.

4. Testosterone.

a. 20 ng/ml in urine in geldings.

b. 55 ng/ml in urine in fillies and mares.

c. Male horses other than geldings will not be tested.

D. The presence of more than one of the four substances identified in subsection B of this section at concentrations greater than the individual thresholds indicated in subsection C of this section or a combination of any two or more substances recognized as androgenic or anabolic is prohibited.

E. Test samples collected from male horses other than geldings must be so identified to the laboratory.

F. Any horse administered an androgenic or anabolic steroid to assist in the recovery from illness or injury may be placed on the veterinarian's list in order to monitor the concentration of the drug or metabolite in urine. After the concentration has fallen below the designated threshold, the horse is eligible to be removed from the list.

G. The stewards shall take disciplinary actions for reports of quantitative testing by the primary testing laboratory indicating the presence of one or more androgenic or anabolic steroid at concentrations above the individual thresholds indicated in subsection C of this section.

1. For the first violation of the regulation pertaining to androgenic and anabolic steroids regarding a particular horse, absent mitigating factors, the recommended penalties are:

a. Disqualification and loss of purse;

b. Fine up to $1,000 at the stewards' discretion if aggravating factors are found; and

c. The horse shall be placed on the veterinarian's list until the concentration has fallen below the designated threshold level.

2. For the second violation of the regulation pertaining to androgenic and anabolic steroids in a 365-day period for the same horse, absent mitigating factors, the recommended penalties are:

a. Disqualification and loss of purse;

b. Fine of $2,500, 90 days suspension; and

c. The horse shall be placed on the veterinarian's list until the concentration has fallen below the designated threshold level.

3. For the third violation of the regulation pertaining to androgenic and anabolic steroids in a 365-day period for the same horse, absent mitigating factors, the recommended penalties are:

a. Disqualification and loss of purse;

b. Revocation of permit; and

c. The horse shall be placed on the veterinarian's list until the concentration has fallen below the designated threshold level.

11VAC10-180-90. Bicarbonate testing.

A. Generally. By this regulation, the Virginia Racing Commission prohibits the feeding or administration to a horse on race day of any bicarbonate-containing substance or other alkalinizing substance that effectively alters the serum or plasma pH or concentration of bicarbonates or carbon dioxide in the horse.

B. Test values. A serum total carbon dioxide level exceeding 37.0 millimoles per liter constitutes a positive test.

C. Testing procedure. The stewards or commission veterinarian may, at their discretion and at any time, order the collection of test samples from any horses present within the enclosure for determination of serum or plasma pH or concentration of bicarbonate, carbon dioxide, or electrolytes. Prerace-testing may be done at a time and manner directed by the commission veterinarian. If testing post race, blood samples shall be taken at least one hour after racing. ~~A~~ Whether prerace or postrace, the sample ~~consisting~~ shall consist of at least two blood tubes ~~shall be~~ taken from the horse to determine the serum total carbon dioxide concentration. If the chief racing chemist finds that the total carbon dioxide levels in the tubes exceed the standard test values of 37.0 millimoles per liter, then he shall inform the stewards of the positive test results.

D. Split samples prohibited. The procedures for split sample testing shall not apply to bicarbonate testing procedures.

E. Disciplinary actions. The stewards shall, absent mitigating circumstances specifically noted in their findings, impose the following disciplinary action for violation of this section:

1. First offense: $2,500 fine and 90-day suspension; loss of purse.

2. Second offense: $5,000 fine and 180-day suspension; loss of purse.

3. Third offense: Revocation of license.

The stewards also may refer the case to the commission for further disciplinary action.

11VAC10-180-100. Collection of samples.

A. Test barn. Test samples shall be collected in the test barn under the supervision of the commission veterinarian or his designee. The commission veterinarian may, at his discretion, permit test samples to be collected in the horse's stall or any other location he deems appropriate. Under these circumstances, the commission veterinarian shall ~~inform the stewards~~ maintain a written record of his decision.

B. Horses to be tested. The stewards or commission veterinarian may, at any time, order the taking of test samples from any horse stabled within the enclosure of the horse racing facility, prior to racing or after racing including qualifying races and official timed workouts for the stewards or commission veterinarian. However, the stewards shall designate at least one horse from each race for the collection of test samples.

C. Collection procedure.

1. The trainer or a permit holder designated by the trainer shall accompany the horse to the test barn and witness the collection and splitting of the samples. The trainer or permit holder designated by the trainer shall cooperate with the commission veterinarian and the commission's veterinary technicians in the performance of their duties. The trainer or permit holder designated by the trainer must remain with the horse until the horse is released from the test barn.

2. Horses, from which samples are to be collected, shall be escorted, following the race, directly to the test barn by the commission's veterinary technicians and the horses shall remain in the test barn until released by the commission veterinarian, his designee, or the test barn supervisor.

3. Stable equipment, other than common necessities for washing and cooling out a horse, is prohibited in the test barn. A practicing veterinarian may attend a horse in the test barn only in the presence of the commission veterinarian or the commission's veterinary technicians.

4. During the collection of test samples, the owner or trainer, or an assistant designated by the owner or trainer, shall be present and witness the collection of the test sample, the splitting of the sample and sealing of containers. In the case of a claimed horse, the owner or trainer, or an assistant designated by the owner or trainer in whose name the horse started, shall be present to witness the collection of the test samples.

5. The test and split samples collected from a horse shall have identification tags affixed. One portion of the tag, bearing a printed identification number, shall remain with the sealed test and split samples, and the other portion of the tag bearing the same printed identification numbers shall be detached in the presence of the witness. The commission veterinarian or his designee shall on the detached portion of the tags identify the horse from which the test and split samples were collected, the race and date, and other information deemed appropriate. The detached portion of the tag shall be witnessed by the trainer or a permit holder designated by the trainer, and shall be retained by the commission veterinarian for safekeeping.

6. A horse's identity shall be confirmed by examining its lip-tattoo number, or for a Standardbred, its freeze brand number. A horse that has not been lip-tattooed or a Standardbred that has not been freeze branded shall be reported immediately to the stewards.

7. If, after a horse remains for a reasonable time in the test barn, a test sample of urine cannot be collected from the horse, the commission veterinarian may, at his discretion, collect a test sample of blood or permit the horse to be returned to its barn where a test sample may be collected under the supervision of the commission veterinarian or the commission's veterinary technicians.

11VAC10-180-110. Laboratory findings and reports.

A. Primary testing laboratory. The commission shall designate a primary testing laboratory for the analysis of test samples collected under the supervision of the commission veterinarian. The commission shall designate a chief racing chemist within the primary testing laboratory who shall have the authority to report his findings to the executive secretary of the commission, the stewards and the commission veterinarian.

B. Reference laboratories. The commission shall designate one or more laboratories, other than the primary testing laboratory, as references laboratories. These laboratories will conduct confirmatory analysis of split samples. Any reference laboratory must be willing to accept split samples for confirmatory testing. Any reference laboratory shall send results to both the person requesting the testing and the commission.

C. Chief racing chemist's responsibilities. The chief racing chemist shall be responsible for safeguarding and analyzing the test samples delivered to the primary testing laboratory. It shall be the chief racing chemist's responsibility to maintain proper equipment, adequate staffing and acceptable procedures to thoroughly and accurately analyze test samples submitted to the primary testing laboratory.

D. Reporting procedures. The chief racing chemist shall submit to the ~~executive secretary of the commission, the stewards and the~~ commission veterinarian a written report as to each test sample analyzed, indicating by identification tag number whether the test sample was negative or there was a chemical identification. All confirmed positive identifications shall be submitted to the executive secretary, the stewards, and the commission veterinarian.

E. Chemical identifications. If the chief racing chemist determines that there is present in the test sample a substance or metabolites of a substance foreign to the natural horse, except those specifically permitted by the regulations of the commission, he shall submit a report of chemical identification to the executive secretary of the commission, the stewards and the commission veterinarian. In a report of chemical identification, the chief racing chemist shall submit evidence acceptable in the scientific community and admissible in court in support of his determination.

F. Review of chemical identifications. Upon receipt of a report of a chemical identification from the chief racing chemist, the stewards shall conduct a review of the chemical identification, which shall include, but not be limited to, the chief racing chemist and the commission veterinarian. During the review, the following procedures shall apply:

1. All references to the report of a chemical identification shall be only by the identification tag number of the sample collected from the horse;

2. The chief racing chemist shall submit his written report of the chemical identification and the evidence supporting his finding;

3. The commission veterinarian shall submit a written statement to the stewards including, but not limited to, the class of the substance, the concentration level detected in the sample, if determined, and its probable effect on a racehorse;

4. The stewards may ask questions at any time and request further documentation as they deem necessary;

5. After receiving the appropriate information on the identified substance, the stewards shall determine whether the chemical identification constitutes a violation of the regulations of the commission and whether it should be deemed a positive test result. In doing so, the stewards shall consider, among other things, the concentration level reported, its likely effect on the horse, and whether environmental contamination may have contributed to the test result;

6. In the event of a positive test result, the stewards shall notify the trainer and the owner of the horse of ~~his~~ the right to send the split sample collected from the horse to one of the reference laboratories, designated by the commission, for confirmatory testing;

7. If the trainer or the owner elects to send the split sample to a reference laboratory, the stewards shall take no disciplinary action against any permit holder until the results from the reference laboratory are received, and the findings shall be a part of the record of any subsequent hearing; and

8. The chief racing chemist's report of a chemical identification, the commission veterinarian's written statement, the results of confirmatory testing and any other documentation submitted to the stewards shall become part of the record of any subsequent proceedings.

G. Barred from racing. No horse from which a positive test sample was collected shall be permitted to race until the stewards have made a final determination in the matter. Such a horse shall not be immune from resulting disciplinary action by the stewards or the commission.

H. Frozen samples. Unconsumed portions of all test samples tested by the primary testing laboratory will be maintained in a frozen state until cleared by the chief racing chemist and permission for their disposal is obtained from the Senior Commonwealth Steward.

I. Split samples. The commission veterinarian or his designee shall determine a minimum test sample requirement for the primary testing laboratory. If the test sample collected is less than the minimum requirement, then the entire test sample shall be sent to the primary laboratory.

If the sample collected is greater than the minimum sample requirement but less than twice that amount, the portion of the test sample that is greater than the minimum test sample requirement shall be secured as the split sample.

If the test sample collected is greater than twice the minimum test sample requirement, a portion of the sample approximately equal to the test sample shipped to the primary testing laboratory shall be secured as the split sample.

J. Storage of split samples. Split samples shall be stored in secured location inside a locked freezer in accordance with the following procedures:

1. Split samples shall be secured in the test barn in the same manner as the portion of the test sample acquired for shipment to the primary laboratory until such time as test samples are packed and secured for shipment to the primary laboratory.

2. Upon packing of the test samples for shipment to the primary laboratory, the split samples shall be transferred to the locked freezer by the commission veterinarian or his authorized designee who shall be responsible for securing possession of the keys.

3. The freezer for storage of split samples shall be opened only for depositing or removing split samples, for inventory, or for checking the condition of split samples.

4. Whenever the freezer used for storage of split samples is opened, it shall be attended by the commission veterinarian or his designee and a representative of the horsemen if the respective horsemen's association has provided a representative. In the case that the split samples from a race must be secured in the freezer and no horsemen's representative is present, the commission veterinarian or his designee shall be in attendance.

5. A log shall be maintained each time the freezer used for storage of split samples is opened to specify each person in attendance, the purpose for opening the freezer, identification of split samples deposited or removed, the date and time the freezer was opened, and the time the freezer was locked.

6. Any evidence of a malfunction of the freezer used for storage of split samples or evidence that split samples are not in a frozen condition shall be documented in the log and immediately reported to the stewards.

K. Shipment of split samples. The trainer or owner of the horse shall have 48 hours from receipt of notice of a positive test result to request that the split sample be shipped to one of the reference laboratories designated by the commission and the split sample shall be shipped to the requested reference laboratory. The cost of shipment and additional testing shall be paid by the permit holder requesting the testing of the split sample. Upon the expiration of this 48-hour period, the trainer or owner relinquishes his right to request a split sample.

L. Chain of custody form. The commission veterinarian, or his designee, shall be responsible for the completion of a chain of custody verification form that shall provide a place for recording the following information:

1. Date and time the split sample is removed from the freezer;

2. The test sample number;

3. The address of the reference laboratory;

4. The name and address where the split sample package is to be taken for shipment to the reference laboratory;

5. Verification of retrieval of the split sample from the freezer;

6. Verification that each specific step of the split sample packaging procedure is in accordance with the recommended procedure;

7. Verification of the address of the reference laboratory on the split sample package;

8. Verification of the condition of the split sample package immediately prior to the transfer of custody to the carrier for shipment to the reference laboratory; and

9. The date and time custody of the split sample package was transferred to the carrier. The commission veterinarian, or his designee, shall witness, attest and sign the form, and a copy of the form shall be supplied to the trainer or owner.

In the event that the trainer or owner of the horse, or his designee, is not present, the commission veterinarian may not remove the split sample from the freezer or ship the split sample to a reference laboratory unless the trainer or owner has declined in writing his option to witness the removal, packaging and shipping procedure.

M. Packaging the split sample. The following procedures shall apply to the packaging of the split sample:

1. The split sample shall be removed from the freezer by the commission veterinarian or his designee; the trainer or owner, or his designee, may be present.

2. The trainer or owner, or his designee, may witness the packaging of the split sample by the commission veterinarian or his designee, in accordance with the instructions supplied by the reference laboratory.

3. The exterior of the package shall be secured and identified with initialed tape, evidence tape or other means to prevent tampering with the package.

4. The trainer or owner, or his designee, may accompany the commission veterinarian or his designee while delivering the package containing the split sample to the location where custody is transferred to the delivery carrier for shipment to the reference laboratory.

5. The trainer or owner, or his designee, may inspect the package containing the split sample immediately prior to transfer to the delivery carrier to verify that the package is intact and has not been tampered with.

6. The trainer or owner, or his designee, if witnessing the procedures, shall sign the chain of custody verification form.

VA.R. Doc. No. R10-2292; Filed May 5, 2010, 11:47 a.m.

TITLE 12. HEALTH

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

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

Final Regulation

Title of Regulation: **12VAC30-50. Amount, Duration, and Scope of Medical and Remedial Care Services (amending 12VAC30-50-100, 12VAC30-50-105, 12VAC30-50-110, 12VAC30-50-140, 12VAC30-50-180).**

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

Effective Date: July 1, 2010.

Agency Contact: Brian McCormick, Regulatory Supervisor, Department of Medical Assistance Services, 600 E. Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-8856, FAX (804) 786-1680, or email brian.mccormick@dmas.virginia.gov.

Summary:

Based upon annual federal Appropriations Act language, particularly P.L. 111-8, which prohibits federal funding (especially Medicaid) for abortion services except in certain circumstances, this amendment was submitted by the Governor of Virginia to the 2010 Virginia General Assembly and adopted as Amendment 91 of the 2010 Virginia Appropriation Act.

Currently the Department of Medical Assistance Services' regulations permit abortion coverage where the life or the health of the mother is at risk. Because the health of the mother is not included under federal law as an exception to the abortion coverage limitation, the Department of Medical Assistance Services is removing the reference to the mother's health from the regulation.

Part III
Amount, Duration and Scope of Services

12VAC30-50-100. Inpatient hospital services provided at general acute care hospitals and freestanding psychiatric hospitals; enrolled providers.

A. Preauthorization of all inpatient hospital services will be performed. This applies to both general acute care hospitals

and freestanding psychiatric hospitals. Nonauthorized inpatient services will not be covered or reimbursed by the Department of Medical Assistance Services (DMAS). Preauthorization shall be based on criteria specified by DMAS. In conjunction with preauthorization, an appropriate length of stay will be assigned using the HCIA, Inc., Length of Stay by Diagnosis and Operation, Southern Region, 1996, as guidelines.

1. Admission review.

a. Planned/scheduled admissions. Review shall be done prior to admission to determine that inpatient hospitalization is medically justified. An initial length of stay shall be assigned at the time of this review. Adverse authorization decisions shall have available a reconsideration process as set out in subdivision 4 of this subsection.

b. Unplanned/urgent or emergency admissions. These admissions will be permitted before any prior authorization procedures. Review shall be performed within one working day to determine that inpatient hospitalization is medically justified. An initial length of stay shall be assigned for those admissions which have been determined to be appropriate. Adverse authorization decisions shall have available a reconsideration process as set out in subdivision 4 of this subsection.

2. Concurrent review shall end for nonpsychiatric claims with dates of admission and services on or after July 1, 1998, with the full implementation of the DRG reimbursement methodology. Concurrent review shall be done to determine that inpatient hospitalization continues to be medically necessary. Prior to the expiration of the previously assigned initial length of stay, the provider shall be responsible for obtaining authorization for continued inpatient hospitalization. If continued inpatient hospitalization is determined necessary, an additional length of stay shall be assigned. Concurrent review shall continue in the same manner until the discharge of the patient from acute inpatient hospital care. Adverse authorization decisions shall have available a reconsideration process as set out in subdivision 4 of this subsection.

3. Retrospective review shall be performed when a provider is notified of a patient's retroactive eligibility for Medicaid coverage. It shall be the provider's responsibility to obtain authorization for covered days prior to billing DMAS for these services. Adverse authorization decisions shall have available a reconsideration process as set out in subdivision 4 of this subsection.

4. Reconsideration process.

a. Providers requesting reconsideration must do so upon verbal notification of denial.

b. This process is available to providers when the nurse reviewers advise the providers by telephone that the medical information provided does not meet DMAS specified criteria. At this point, the provider must request by telephone a higher level of review if he disagrees with the nurse reviewer's findings. If higher level review is not requested, the case will be denied and a denial letter generated to both the provider and recipient identifying appeal rights.

c. If higher level review is requested, the authorization request will be held in suspense and referred to the Utilization Management Supervisor (UMS). The UMS shall have one working day to render a decision. If the UMS upholds the adverse decision, the provider may accept that decision and the case will be denied and a denial letter identifying appeal rights will be generated to both the provider and the recipient. If the provider continues to disagree with the UMS' adverse decision, he must request physician review by DMAS medical support. If higher level review is requested, the authorization request will be held in suspense and referred to DMAS medical support for the last step of reconsideration.

d. DMAS medical support will review all case specific medical information. Medical support shall have two working days to render a decision. If medical support upholds the adverse decision, the request for authorization will then be denied and a letter identifying appeal rights will be generated to both the provider and the recipient. The entire reconsideration process must be completed within three working days.

5. Appeals process.

a. Recipient appeals. Upon receipt of a denial letter, the recipient shall have the right to appeal the adverse decision. Under the Client Appeals regulations, Part I (12VAC30-110-10 et seq.) of 12VAC30-110, the recipient shall have 30 days from the date of the denial letter to file an appeal.

b. Provider appeals. If the reconsideration steps are exhausted and the provider continues to disagree, upon receipt of the denial letter, the provider shall have 30 days from the date of the denial letter to file an appeal if the issue is whether DMAS will reimburse the provider for services already rendered. The appeal shall be held in accordance with the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia).

B. Out-of-state inpatient general acute care hospitals and freestanding psychiatric hospitals, enrolled providers. In addition to meeting all of the preauthorization requirements specified in subsection A of this section, out-of-state hospitals must further demonstrate that the requested admission meets at least one of the following additional standards. Services

provided out of state for circumstances other than these specified reasons shall not be covered.

1. The medical services must be needed because of a medical emergency;

2. Medical services must be needed and the recipient's health would be endangered if he were required to travel to his state of residence;

3. The state determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state;

4. It is the general practice for recipients in a particular locality to use medical resources in another state.

C. Cosmetic surgical procedures shall not be covered unless performed for physiological reasons and require DMAS prior approval.

D. Reimbursement for induced abortions is provided in only those cases in which there would be a substantial endangerment to ~~health or~~ life of the mother if the fetus were carried to term.

E. Coverage of inpatient hospitalization shall be limited to a total of 21 days per admission in a 60-day period for the same or similar diagnosis or treatment plan. The 60-day period would begin on the first hospitalization (if there are multiple admissions) admission date. There may be multiple admissions during this 60-day period. Claims which exceed 21 days per admission within 60 days for the same or similar diagnosis or treatment plan will not be authorized for payment. Claims which exceed 21 days per admission within 60 days with a different diagnosis or treatment plan will be considered for reimbursement if medically indicated. Except as previously noted, regardless of authorization for the hospitalization, the claims will be processed in accordance with the limit for 21 days in a 60-day period. Claims for stays exceeding 21 days in a 60-day period shall be suspended and processed manually by DMAS staff for appropriate reimbursement. The limit for coverage of 21 days for nonpsychiatric admissions shall cease with dates of service on or after July 1, 1998.

EXCEPTION: SPECIAL PROVISIONS FOR ELIGIBLE INDIVIDUALS UNDER 21 YEARS OF AGE: Consistent with 42 CFR 441.57, payment of medical assistance services shall be made on behalf of individuals under 21 years of age, who are Medicaid eligible, for medically necessary stays in general hospitals and freestanding psychiatric hospitals in excess of 21 days per admission when such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a physical or psychological, as appropriate, examination. The admission and length of stay must be medically justified and preauthorized via the admission and concurrent or retrospective review processes described in subsection A of this section. Medically unjustified days in such hospitalizations shall not be authorized for payment.

F. Mandatory lengths of stay.

1. Coverage for a normal, uncomplicated vaginal delivery shall be limited to the day of delivery plus an additional two days unless additional days are medically justified. Coverage for cesarean births shall be limited to the day of delivery plus an additional four days unless additional days are medically justified.

2. Coverage for a radical or modified radical mastectomy for treatment of disease or trauma of the breast shall be provided for a minimum of 48 hours. Coverage for a total or partial mastectomy with lymph node dissection for treatment of disease or trauma of the breast shall be provided for a minimum of 24 hours. Additional days beyond the specified minimums for either radical, modified, total, or partial mastectomies may be covered if medically justified and prior authorized until the diagnosis related grouping methodology is fully implemented. Nothing in this chapter shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate.

G. Coverage in freestanding psychiatric hospitals shall not be available for individuals aged 21 through 64. Medically necessary inpatient psychiatric care rendered in a psychiatric unit of a general acute care hospital shall be covered for all Medicaid eligible individuals, regardless of age, within the limits of coverage prescribed in this section and 12VAC30-50-105.

H. For the purposes of organ transplantation, all similarly situated individuals will be treated alike. Transplant services for kidneys, corneas, hearts, lungs, and livers shall be covered for all eligible persons. High dose chemotherapy and bone marrow/stem cell transplantation shall be covered for all eligible persons with a diagnosis of lymphoma, breast cancer, leukemia, or myeloma. Transplant services for any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be limited to children (under 21 years of age). Kidney, liver, heart, and bone marrow/stem cell transplants and any other medically necessary transplantation procedures that are determined to not be experimental or investigational require preauthorization by DMAS medical support. Inpatient hospitalization related to kidney transplantation will require preauthorization at the time of admission and, concurrently, for length of stay. Cornea transplants do not require preauthorization of the procedure, but inpatient hospitalization related to such transplants will require preauthorization for admission and, concurrently, for length of stay. The patient must be considered acceptable for coverage and treatment. The treating facility and transplant

staff must be recognized as being capable of providing high quality care in the performance of the requested transplant. Standards for coverage of organ transplant services are in 12VAC30-50-540 through 12VAC30-50-580.

I. In compliance with federal regulations at 42 CFR 441.200, Subparts E and F, claims for hospitalization in which sterilization, hysterectomy or abortion procedures were performed shall be subject to review. Hospitals must submit the required DMAS forms corresponding to the procedures. Regardless of authorization for the hospitalization during which these procedures were performed, the claims shall suspend for manual review by DMAS. If the forms are not properly completed or not attached to the bill, the claim will be denied or reduced according to DMAS policy.

12VAC30-50-105. Inpatient hospital services provided at general acute care hospitals and freestanding psychiatric hospitals; nonenrolled providers (nonparticipating/out of state).

A. The full DRG inpatient reimbursement methodology shall become effective July 1, 1998, for general acute care hospitals and freestanding psychiatric hospitals which are nonenrolled providers (nonparticipating/out of state) and the same reviews, criteria, and requirements shall apply as are applied to enrolled, in-state, participating hospitals in 12VAC30-50-100.

B. Inpatient hospital services rendered by nonenrolled providers shall not require prior authorization with the exception of transplants as described in subsection K of this section and this subsection. However, these inpatient hospital services claims will be suspended from automated computer payment and will be manually reviewed for medical necessity as described in subsections B through K of this section using criteria specified by DMAS. Inpatient hospital services provided out of state to a Medicaid recipient who is a resident of the Commonwealth of Virginia shall only be reimbursed under at least one of the following conditions. It shall be the responsibility of the hospital, when requesting prior authorization for the admission, to demonstrate that one of the following conditions exists in order to obtain authorization.

1. The medical services must be needed because of a medical emergency;

2. Medical services must be needed and the recipient's health would be endangered if he were required to travel to his state of residence;

3.The state determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state;

4. It is the general practice for recipients in a particular locality to use medical resources in another state.

C. Medicaid inpatient hospital admissions (lengths-of-stay) are limited to the 75th percentile of PAS (Professional Activity Study of the Commission on Professional and Hospital Activities) diagnostic/procedure limits. For admissions under four days that exceed the 75th percentile, the hospital must attach medical justification records to the billing invoice to be considered for additional coverage when medically justified. For all admissions that exceed three days up to a maximum of 21 days, the hospital must attach medical justification records to the billing invoice. (See the exception to subsection H of this section.)

D. Cosmetic surgical procedures shall not be covered unless performed for physiological reasons and require DMAS prior approval.

E. Reimbursement for induced abortions is provided in only those cases in which there would be a substantial endangerment to ~~health or~~ life of the mother if the fetus was carried to term.

F. Hospital claims with an admission date prior to the first surgical date, regardless of the number of days prior to surgery, must be medically justified. The hospital must write on or attach the justification to the billing invoice for consideration of reimbursement for all pre-operative days. Medically justified situations are those where appropriate medical care cannot be obtained except in an acute hospital setting thereby warranting hospital admission. Medically unjustified days in such admissions will be denied.

G. Reimbursement will not be provided for weekend (Saturday/Sunday) admissions, unless medically justified. Hospital claims with admission dates on Saturday or Sunday will be pended for review by medical staff to determine appropriate medical justification for these days. The hospital must write on or attach the justification to the billing invoice for consideration of reimbursement coverage for these days. Medically justified situations are those where appropriate medical care cannot be obtained except in an acute hospital setting thereby warranting hospital admission. Medically unjustified days in such admission will be denied.

H. Coverage of inpatient hospitalization shall be limited to a total of 21 days per admission in a 60-day period for the same or similar diagnosis or treatment plan. The 60-day period would begin on the first hospitalization (if there are multiple admissions) admission date. There may be multiple admissions during this 60-day period. Claims which exceed 21 days per admission within 60 days for the same or similar diagnosis or treatment plan will not be reimbursed. Claims which exceed 21 days per admission within 60 days with a different diagnosis or treatment plan will be considered for reimbursement if medically justified. The admission and length of stay must be medically justified and preauthorized via the admission and concurrent review processes described in subsection A of 12VAC30-50-100. Claims for stays exceeding 21 days in a 60-day period shall be suspended and processed manually by DMAS staff for appropriate reimbursement. The limit for coverage of 21 days shall cease

with dates of service on or after July 1, 1998. Medically unjustified days in such hospitalizations shall not be reimbursed by DMAS.

EXCEPTION: SPECIAL PROVISIONS FOR ELIGIBLE INDIVIDUALS UNDER 21 YEARS OF AGE: Consistent with 42 CFR 441.57, payment of medical assistance services shall be made on behalf of individuals under 21 years of age who are Medicaid eligible for medically necessary stays in general hospitals and freestanding psychiatric facilities in excess of 21 days per admission when such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a physical or psychological, as appropriate, examination.

I. Mandatory lengths of stay.

1. Coverage for a normal, uncomplicated vaginal delivery shall be limited to the day of delivery plus an additional two days unless additional days are medically justified. Coverage for cesarean births shall be limited to the day of delivery plus an additional four days unless additional days are medically necessary.

2. Coverage for a radical or modified radical mastectomy for treatment of disease or trauma of the breast shall be provided for a minimum of 48 hours. Coverage for a total or partial mastectomy with lymph node dissection for treatment of disease or trauma of the breast shall be provided for a minimum of 24 hours. Additional days beyond the specified minimums for either radical, modified, total, or partial mastectomies may be covered if medically justified and prior authorized until the diagnosis related grouping methodology is fully implemented. Nothing in this chapter shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate.

J. Reimbursement will not be provided for inpatient hospitalization for those surgical and diagnostic procedures listed on the DMAS outpatient surgery list unless the inpatient stay is medically justified or meets one of the exceptions.

K. For purposes of organ transplantation, all similarly situated individuals will be treated alike. Transplant services for kidneys, corneas, hearts, lungs, and livers shall be covered for all eligible persons. High dose chemotherapy and bone marrow/stem cell transplantation shall be covered for all eligible persons with a diagnosis of lymphoma, breast cancer, leukemia or myeloma. Transplant services for any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be limited to children (under 21 years of age). Kidney, liver, heart, bone marrow/stem cell transplants and any other medically necessary transplantation procedures that are determined to not be experimental or investigational require preauthorization by DMAS. Cornea transplants do not require preauthorization. The patient must be considered acceptable for coverage and treatment. The treating facility and transplant staff must be recognized as being capable of providing high quality care in the performance of the requested transplant. Standards for coverage of organ transplant services are in 12VAC30-50-540 through 12VAC30-50-580.

L. In compliance with 42 CFR 441.200, Subparts E and F, claims for hospitalization in which sterilization, hysterectomy or abortion procedures were performed shall be subject to review of the required DMAS forms corresponding to the procedures. The claims shall suspend for manual review by DMAS. If the forms are not properly completed or not attached to the bill, the claim will be denied or reduced according to DMAS policy.

12VAC30-50-110. Outpatient hospital and rural health clinic services.

A. Outpatient hospital services.

1. Outpatient hospital services means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that:

a. Are furnished to outpatients;

b. Except in the case of nurse-midwife services, as specified in 42 CFR 440.165, are furnished by or under the direction of a physician or dentist; and

c. Are furnished by an institution that:

(1) Is licensed or formally approved as a hospital by an officially designated authority for state standard-setting; and

(2) Except in the case of medical supervision of nurse-midwife services, as specified in 42 CFR 440.165, meets the requirements for participation in Medicare.

2. Reimbursement for induced abortions is provided in only those cases in which there would be substantial endangerment of ~~health or~~ life to the mother if the fetus was carried to term.

3. The following limits and requirements shall apply to DMAS coverage of outpatient observation beds.

a. Observation bed services shall be covered when they are reasonable and necessary to evaluate a medical condition to determine appropriate level of treatment.

b. Nonroutine observation for underlying medical complications, as explained in documentation attached to the provider's claim for payment, after surgery or diagnostic services shall be covered. Routine use of an observation bed shall not be covered. Noncovered routine use shall be:

(1) Routine preparatory services and routine recovery time for outpatient surgical or diagnostic testing services (e.g., services for routine post-operative monitoring during a normal recovery period (four to six hours)).

(2) Observation services provided in conjunction with emergency room services, unless, following the emergency treatment, there are clear medical complications which must be managed by a physician other than the original emergency physician.

(3) Any substitution of an outpatient observation service for a medically appropriate inpatient admission.

c. These services must be billed as outpatient care and may be provided for up to 23 hours. A patient stay of 24 hours or more shall require inpatient precertification, where applicable.

d. When inpatient admission is required following observation services and prior approval has been obtained for the inpatient stay, observation charges must be combined with the appropriate inpatient admission and be shown on the inpatient claim for payment. Observation bed charges and inpatient hospital charges shall not be reimbursed for the same day.

B. Rural health clinic services and other ambulatory services furnished by a rural health clinic.

The same service limitations apply to rural health clinics as to all other services.

C. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with § 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

The same service limitations apply to FQHCs as to all other services.

12VAC30-50-140. Physician's services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere.

A. Elective surgery as defined by the Program is surgery that is not medically necessary to restore or materially improve a body function.

B. Cosmetic surgical procedures are not covered unless performed for physiological reasons and require Program prior approval.

C. Routine physicals and immunizations are not covered except when the services are provided under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program and when a well-child examination is performed in a private physician's office for a foster child of the local social services department on specific referral from those departments.

D. Outpatient psychiatric services.

1. Psychiatric services are limited to an initial availability of 26 sessions, without prior authorization during the first treatment year. An additional extension of up to 26 sessions during the first treatment year must be prior authorized by DMAS or its designee. The availability is further restricted to no more than 26 sessions each succeeding year when prior authorized by DMAS or its designee. Psychiatric services are further restricted to no more than three sessions in any given seven-day period. Consistent with § 6403 of the Omnibus Budget Reconciliation Act of 1989, medically necessary psychiatric services shall be covered when prior authorized by DMAS or its designee for individuals younger than 21 years of age when the need for such services has been identified in an EPSDT screening.

2. Psychiatric services can be provided by psychiatrists or by a licensed clinical social worker, licensed professional counselor, licensed clinical nurse specialist-psychiatric, or a licensed marriage and family therapist under the direct supervision of a psychiatrist.*

3. Psychological and psychiatric services shall be medically prescribed treatment that is directly and specifically related to an active written plan designed and signature-dated by either a psychiatrist or by a licensed clinical social worker, licensed professional counselor, licensed clinical nurse specialist-psychiatric, or licensed marriage and family therapist under the direct supervision of a psychiatrist.*

4. Psychological or psychiatric services shall be considered appropriate when an individual meets the following criteria:

a. Requires treatment in order to sustain behavioral or emotional gains or to restore cognitive functional levels that have been impaired;

b. Exhibits deficits in peer relations, dealing with authority; is hyperactive; has poor impulse control; is clinically depressed or demonstrates other dysfunctional clinical symptoms having an adverse impact on attention and concentration, ability to learn, or ability to participate in employment, educational, or social activities;

c. Is at risk for developing or requires treatment for maladaptive coping strategies; and

d. Presents a reduction in individual adaptive and coping mechanisms or demonstrates extreme increase in personal distress.

5. Psychological or psychiatric services may be provided in an office or a mental health clinic.

E. Any procedure considered experimental is not covered.

F. Reimbursement for induced abortions is provided in only those cases in which there would be a substantial

endangerment of ~~health or~~ life to the mother if the fetus was carried to term.

G. Physician visits to inpatient hospital patients over the age of 21 are limited to a maximum of 21 days per admission within 60 days for the same or similar diagnoses or treatment plan and is further restricted to medically necessary authorized (for enrolled providers)/approved (for nonenrolled providers) inpatient hospital days as determined by the Program.

EXCEPTION: SPECIAL PROVISIONS FOR ELIGIBLE INDIVIDUALS UNDER 21 YEARS OF AGE: Consistent with 42 CFR 441.57, payment of medical assistance services shall be made on behalf of individuals under 21 years of age, who are Medicaid eligible, for medically necessary stays in general hospitals and freestanding psychiatric facilities in excess of 21 days per admission when such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a physical examination. Payments for physician visits for inpatient days shall be limited to medically necessary inpatient hospital days.

H. (Reserved.)

I. Reimbursement shall not be provided for physician services provided to recipients in the inpatient setting whenever the facility is denied reimbursement.

J. (Reserved.)

K. For the purposes of organ transplantation, all similarly situated individuals will be treated alike. Transplant services for kidneys, corneas, hearts, lungs, and livers shall be covered for all eligible persons. High dose chemotherapy and bone marrow/stem cell transplantation shall be covered for all eligible persons with a diagnosis of lymphoma, breast cancer, leukemia, or myeloma. Transplant services for any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be limited to children (under 21 years of age). Kidney, liver, heart, and bone marrow/stem cell transplants and any other medically necessary transplantation procedures that are determined to not be experimental or investigational require preauthorization by DMAS. Cornea transplants do not require preauthorization. The patient must be considered acceptable for coverage and treatment. The treating facility and transplant staff must be recognized as being capable of providing high quality care in the performance of the requested transplant. Standards for coverage of organ transplant services are in 12VAC30-50-540 through 12VAC30-50-580.

L. Breast reconstruction/prostheses following mastectomy and breast reduction.

1. If prior authorized, breast reconstruction surgery and prostheses may be covered following the medically necessary complete or partial removal of a breast for any medical reason. Breast reductions shall be covered, if prior authorized, for all medically necessary indications. Such procedures shall be considered noncosmetic.

2. Breast reconstruction or enhancements for cosmetic reasons shall not be covered. Cosmetic reasons shall be defined as those which are not medically indicated or are intended solely to preserve, restore, confer, or enhance the aesthetic appearance of the breast.

M. Admitting physicians shall comply with the requirements for coverage of out-of-state inpatient hospital services. Inpatient hospital services provided out of state to a Medicaid recipient who is a resident of the Commonwealth of Virginia shall only be reimbursed under at least one the following conditions. It shall be the responsibility of the hospital, when requesting prior authorization for the admission, to demonstrate that one of the following conditions exists in order to obtain authorization. Services provided out of state for circumstances other than these specified reasons shall not be covered.

1. The medical services must be needed because of a medical emergency;

2. Medical services must be needed and the recipient's health would be endangered if he were required to travel to his state of residence;

3. The state determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state;

4. It is general practice for recipients in a particular locality to use medical resources in another state.

N. In compliance with 42 CFR 441.200, Subparts E and F, claims for hospitalization in which sterilization, hysterectomy or abortion procedures were performed shall be subject to review of the required DMAS forms corresponding to the procedures. The claims shall suspend for manual review by DMAS. If the forms are not properly completed or not attached to the bill, the claim will be denied or reduced according to DMAS policy.

O. Prior authorization is required for the following nonemergency outpatient procedures: Magnetic Resonance Imaging (MRI), including Magnetic Resonance Angiography (MRA), Computerized Axial Tomography (CAT) scans, including Computed Tomography Angiography (CTA), or Positron Emission Tomography (PET) scans performed for the purpose of diagnosing a disease process or physical injury. The referring physician ordering nonemergency outpatient Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (CAT) scans, or Positron Emission Tomography (PET) scans must obtain prior authorization from the Department of Medical Assistance Services (DMAS) for those scans. The servicing provider will

not be reimbursed for the scan unless proper prior authorization is obtained from DMAS by the referring physician.

P. Outpatient substance abuse treatment services shall be limited to an initial availability of 26 therapy sessions without prior authorization during the first treatment year. An additional extension of up to 26 sessions during the first treatment year must be prior authorized by DMAS or its designee. The availability is further restricted to no more than 26 therapy sessions each succeeding year when prior authorized by DMAS or its designee. Outpatient substance abuse treatment services are further restricted to no more than three sessions in any given seven-day period. Consistent with § 6403 of the Omnibus Budget Reconciliation Act of 1989, medically necessary substance abuse services shall be covered when prior authorized by DMAS or its designee for individuals younger than 21 years of age when the need for such services has been identified in an EPSDT screening and the above limits have been exceeded.

1. Outpatient substance abuse services shall be provided by medical doctors or by doctors of osteopathy who have completed three years of post-graduate residency training in psychiatry; or by a physician or doctor of osteopathy who is certified in addiction medicine. The provider must also be qualified by training and experience in all of the following areas of substance abuse/addiction counseling: clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; and professional and ethical responsibilities. Outpatient substance abuse treatment services are further defined in 12VAC30-50-228.

2. Psychological and psychiatric substance abuse services shall be prescribed treatment that is directly and specifically related to an active written plan designed and signature-dated by one of the professionals listed in subdivision 1 of this subsection.

3. Psychological or psychiatric substance abuse services shall be considered appropriate when an individual meets the criteria for an Axis I substance-related disorder. Nicotine or caffeine abuse or dependence shall not be covered. The Axis I substance-related disorder shall meet American Society of Addiction Medicine (ASAM) Level of Care Criteria as prescribed in Patient Placement Criteria for the Treatment of Substance-Related Disorders (ASAM PPC-2R), Second Edition.

4. Psychological or psychiatric substance abuse services may be provided in an office or a clinic under the direction of a physician.

*Licensed clinical social workers, licensed professional counselors, licensed clinical nurse specialists-psychiatric, and licensed marriage and family therapists may also directly enroll or be supervised by psychologists as provided for in 12VAC30-50-150.

12VAC30-50-180. Clinic services.

A. Reimbursement for induced abortions is provided in only those cases in which there would be a substantial endangerment of ~~health or~~ life to the mother if the fetus were carried to term.

B. Clinic services means preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that:

1. Are provided to outpatients;

2. Are provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients; and

3. Except in the case of nurse-midwife services, as specified in 42 CFR 440.165, are furnished by or under the direction of a physician or dentist.

C. Reimbursement to community mental health clinics for medical psychotherapy services is provided only when performed by a qualified therapist. For purposes of this section, a qualified therapist is:

1. A licensed physician who has completed three years of post-graduate residency training in psychiatry;

2. An individual licensed by one of the boards administered by the Department of Health Professions to provide medical psychotherapy services including: licensed clinical psychologists, licensed clinical social workers, licensed professional counselors, clinical nurse specialists-psychiatric, or licensed marriage and family therapists; or

3. An individual who holds a master's or doctorate degree, who has completed all coursework necessary for licensure by one of the appropriate boards as specified in subdivision 2 of this subsection, and who has applied for a license but has not yet received such license, and who is currently supervised in furtherance of the application for such license, in accordance with requirements or regulations promulgated by DMAS, by one of the licensed practitioners listed in subdivisions 1 and 2 of this subsection.

D. Coverage of community mental health clinics for substance abuse treatment services, as further defined in 12VAC30-50-228, is provided only when performed by a qualified therapist and consistent with an active written plan designed and signature-dated. For purposes of providing this service a qualified therapist shall be:

1. Physicians and doctors of osteopathy who have completed three years of post-graduate residency training in psychiatry or by a physician or doctor of osteopathy who is certified in addiction medicine.

2. A licensed clinical psychologist, licensed clinical social worker, licensed professional counselor, licensed psychiatric clinical nurse specialist, a licensed psychiatric nurse practitioner, a licensed marriage and family therapist, or a licensed substance abuse treatment practitioner. The provider must also be qualified by training and experience in all of the following areas of substance abuse/addiction counseling: clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; and professional and ethical responsibilities.

3. An individual who holds a master's or doctorate degree, who has completed all coursework necessary for licensure by the respective board, and who has applied for a license but has not yet received such license, and who is currently supervised in furtherance of the application for such license, in accordance with requirements or regulations promulgated by DMAS, by one of the licensed practitioners listed in this subsection.

4. An individual who holds a bachelor's degree in any field and certification as a substance abuse counselor (CSAC) or an individual who holds a bachelor's degree and is a certified addictions counselor (CAC) who is under the direct supervision of one of the licensed practitioners listed in subdivision C 1 or 2 of this subsection.

VA.R. Doc. No. R10-2400; Filed May 5, 2010, 10:55 a.m.

Final Regulation

Titles of Regulations: **12VAC30-10. State Plan Under Title XIX of the Social Security Act Medical Assistance Program; General Provisions (amending 12VAC30-10-690).**

12VAC30-70. Methods and Standards for Establishing Payment Rates - Inpatient Hospital Services (amending 12VAC30-70-50, 12VAC30-70-221, 12VAC30-70-291, 12VAC30-70-301, 12VAC30-70-351, 12VAC30-70-391).

12VAC30-80. Methods and Standards for Establishing Payment Rates; Other Types of Care (amending 12VAC30-80-180, 12VAC30-80-190, 12VAC30-80-200).

12VAC30-90. Methods and Standards for Establishing Payment Rates for Long-Term Care (amending 12VAC30-90-41).

Statutory Authority: § 32.1-325 of the Code of Virginia; Title XIX of the Social Security Act (42 USC § 1396 et seq.).

Effective Date: July 1, 2010.

Agency Contact: Brian McCormick, Regulatory Supervisor, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-8856, FAX (804) 786-1680, or email brian.mccormick@dmas.virginia.gov.

Summary:

This regulatory action implements reimbursement changes mandated by the Virginia General Assembly in the 2010 Appropriation Act (Act) to be effective July 1, 2010 as follows:

Reimbursement Changes Affecting Hospitals (12VAC30-70) is amended to (i) eliminate the inflation adjustment for long-stay hospitals and freeze ceilings in state fiscal year (SFY) 2011 and 2012 as mandated by Item 297 AAA of the Act; (ii) rebase hospital diagnosis-related group weights, case rates, psychiatric, and rehabilitation per diem rates and eliminate the SFY 2012 inflation adjustment for hospital operating rates as mandated by Item 297 BBB 1 a of the Act; (iii) change the inpatient hospital Medicaid utilization from 15% to 14% to determine Disproportionate Share Hospital (DSH) eligibility, rebase the DSH reimbursement for all hospitals, and eliminate the SFY 2012 inflation adjustment for hospital DSH payments as mandated by Item 297 BBB 1 b of the Act; (iv) eliminate inflation for graduate medical education per resident amounts in SFYs 2011 and 2012 as directed by Item 297 BBB 1 c of the Act; (v) eliminate rebasing in SFY 2011 and inflation in SFYs 2011 and 2012 for freestanding psychiatric hospital facilities as directed by Item 287 CCC of the Act; and (vi) exclude certain out-of-state hospitals from receiving indirect medical education payments and reduce DSH payments to certain out-of-state hospitals, as mandated by Item 297 TTT of the Act.

Reimbursement Changes Affecting Other Providers (12VAC30-80) is amended to (i) eliminate the inflation adjustments for home health agencies for SFYs 2011 and 2012 as mandated by Item 297 FFF of the Act; (ii) reduce rates for procedure codes determined under resource based relative value system by 3.0% in SFY 2011 and an additional 1.0% in SFY 2012 as mandated by Item 297 CCC of the Act; and (iii) eliminate the inflation adjustments in SFYs 2011 and 2012 for outpatient rehabilitation agencies as mandated by Item 297 GGG of the Act.

Reimbursement Changes Affecting Nursing Facilities (12VAC30-90) is amended to (i) eliminate rebasing in SFY 2011 and inflation in SFYs 2011 and 2012 as directed by Item 306 DDD 1 a of the Act; and (ii) freeze nursing facility and specialized care ceilings.

In addition, this action amends 12VAC30-10-690 by expanding the basis for termination of a Medicaid provider in conformance with Chapter 785 of the 2010 Acts of Assembly.

12VAC30-10-690. Exclusion of providers and suspension of practitioners and other individuals.

A. All of the requirements of 42 CFR 1002, Subpart B are met.

In addition to meeting all federal requirements, the agency, under the authority of state law, imposes broader sanctions.

B. The Medicaid agency meets the requirements of:

1. § 1902(p) of the Act by excluding from participation:

a. At the state's discretion, any individual or entity for any reason for which the Secretary could exclude the individual or entity from participation in a program under Title XVIII in accordance with § 1128, 1128A, or 1866(b)(2).

b. Any HMO (as defined in § 1903(m) of the Act) or an entity furnishing services under a waiver approved under § 1915(b)(1) of the Act, that:

(1) Could be excluded under § 1128(b)(8) relating to owners and managing employees who have been convicted of certain crimes or received other sanctions; or

(2) Has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that is described in § 1128(b)(8)(B) of the Act.

2. An MCO, PIHP, PAHP, or PCCM may not have prohibited affiliations with individuals (as defined in 42 CFR 438.610(b)) who are debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. If the Commonwealth finds that an MCO, PCCM, PIHP, or PAHP is not in compliance, the Commonwealth will comply with the requirements of 42 CFR 438.610(c).

3. § 1902(a)(39) of the Act by:

a. Excluding an individual or entity from participation for the period specified by the Secretary, when required by the Secretary to do so in accordance with § 1128 or 1128A of the Act; and

b. Providing that no payment will be made with respect to any item or service furnished by an individual or entity during this period.

C. The Medicaid agency meets the requirements of:

1. § 1902(a)(41) of the Act with respect to prompt notification to HCFA whenever a provider is terminated, suspended, sanctioned, or otherwise excluded from participating under this state plan; and

2. § 1902(a)(49) of the Act with respect to providing information and access to information regarding sanctions taken against health care practitioners and providers by state licensing authorities in accordance with § 1921 of the Act.

D. Provider terminations or exclusions shall be in accordance with § 32.1-325 D and E of the Code of Virginia.

12VAC30-70-50. Hospital reimbursement system.

The reimbursement system for hospitals includes the following components:

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

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

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

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

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

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

under this new methodology will become the base for computing the next prospective year ceiling.

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

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

Effective on and after July 1, 1992, for providers subject to the prospective payment system, the allowance for inflation, as described above, which became effective on July 1, 1989, shall be converted to an escalation factor by adding two percentage points, (200 basis points) to the then current allowance for inflation. The escalation factor shall be applied in accordance with the inpatient hospital reimbursement methodology in effect on June 30, 1992. On July 1, 1992, the conversion to the new escalation factor shall be accomplished by a transition methodology which, for non-June 30 year end hospitals, applies the escalation factor to escalate their payment rates for the months between July 1, 1992, and their next fiscal year ending on or before May 31, 1993.

Effective July 1, 2010, through June 30, 2012, the escalation factor shall be zero. In addition, ceilings shall remain at the same level as the ceilings for long stay hospitals with fiscal year's end of June 30, 2010.

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

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

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

Depreciation, capital interest, and education costs approved pursuant to PRM-15 (§ 400), shall be considered as pass throughs and not part of the calculation. Capital interest is reimbursed the percentage of allowable cost specified in 12VAC30-70-271.

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

The table below presents three examples under the new plan:

Group Ceiling	Hospital's Allow-able Cost Per Day	$	Dif-ference % or Ceiling	$	Sliding Scale Incentive % of Dif-ference
$230.00	$230.00	-0-	-0-	-0-	-0-
230.00	207.00	23.00	10%	2.30	10%
230.00	172.00	57.50	25%	14.38	25%
230.00	143.00	76.00	33%	19.00	25%

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

G. Disproportionate share hospitals defined.

The following criteria shall be met before a hospital is determined to be eligible for a disproportionate share payment adjustment.

1. Criteria.

a. A Medicaid inpatient utilization rate in excess of 8% for hospitals receiving Medicaid payments in the Commonwealth, or a low-income patient utilization rate exceeding 25% (as defined in the Omnibus Budget Reconciliation Act of 1987 and as amended by the Medicare Catastrophic Coverage Act of 1988); and

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

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

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

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

2. Payment adjustment.

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

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

c. No payments made under subdivision 1 or 2 of this subsection shall exceed any applicable limitations upon such payments established by federal law or regulations.

H. Outlier adjustments.

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

2. DMAS shall pay to disproportionate share hospitals (as defined in paragraph G above) an outlier adjustment in payment amounts for medically necessary inpatient hospital services provided on or after July 1, 1991, involving exceptionally high costs for individuals under six years of age.

3. The outlier adjustment calculation.

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

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

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

d. DMAS shall pay as an outlier adjustment to each eligible hospital all per diem operating costs which exceed the applicable threshold or thresholds for that hospital.

4. Pursuant to 12VAC30-50-100, there is no limit on length of time for medically necessary stays for individuals under six years of age. This section provides that consistent with 42 CFR 441.57, payment of medical assistance services shall be made on behalf of individuals under 21 years of age, who are Medicaid eligible, for medically necessary stays in acute care facilities in excess of 21 days per admission when such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a physical examination. Medical documentation justifying admission and the continued length of stay must be attached to or written on the invoice for review by medical staff to determine medical necessity. Medically unjustified days in such admissions will be denied.

Article 2
Prospective (DRG-Based) Payment Methodology

12VAC30-70-221. General.

A. Effective July 1, 2000, the prospective (DRG-based) payment system described in this article shall apply to inpatient hospital services provided in enrolled general acute care hospitals, rehabilitation hospitals, and freestanding psychiatric facilities licensed as hospitals, unless otherwise noted.

B. The following methodologies shall apply under the prospective payment system:

1. As stipulated in 12VAC30-70-231, operating payments for DRG cases that are not transfer cases shall be determined on the basis of a hospital specific operating rate per case times relative weight of the DRG to which the case is assigned.

2. As stipulated in 12VAC30-70-241, operating payments for per diem cases shall be determined on the basis of a hospital specific operating rate per day times the covered days for the case with the exception of payments for per diem cases in freestanding psychiatric facilities. Payments for per diem cases in freestanding psychiatric facilities licensed as hospitals shall be determined on the basis of a hospital specific rate per day that represents an all-inclusive payment for operating and capital costs.

3. As stipulated in 12VAC30-70-251, operating payments for transfer cases shall be determined as follows: (i) the transferring hospital shall receive an operating per diem payment, not to exceed the DRG operating payment that would have otherwise been made and (ii) the final discharging hospital shall receive the full DRG operating payment.

4. As stipulated in 12VAC30-70-261, additional operating payments shall be made for outlier cases. These additional payments shall be added to the operating payments determined in subdivisions 1 and 3 of this subsection.

5. As stipulated in 12VAC30-70-271, payments for capital costs shall be made on an allowable cost basis.

6. As stipulated in 12VAC30-70-281, payments for direct medical education costs of nursing schools and paramedical programs shall be made on an allowable cost basis. Payment for direct graduate medical education (GME) costs for interns and residents shall be made quarterly on a prospective basis, subject to cost settlement based on the number of full time equivalent (FTE) interns and residents as reported on the cost report.

7. As stipulated in 12VAC30-70-291, payments for indirect medical education costs shall be made quarterly on a prospective basis.

8. As stipulated in 12VAC30-70-301, payments to hospitals that qualify as disproportionate share hospitals shall be made quarterly on a prospective basis.

C. The terms used in this article shall be defined as provided in this subsection:

"Base year" means the state fiscal year for which data is used to establish the DRG relative weights, the hospital case-mix indices, the base year standardized operating costs per case, and the base year standardized operating costs per day. The base year will change when the DRG payment system is rebased and recalibrated. In subsequent rebasings, the Commonwealth shall notify affected providers of the base year to be used in this calculation.

"Base year standardized costs per case" reflects the statewide average hospital costs per discharge for DRG cases in the base year. The standardization process removes the effects of case-mix and regional variations in wages from the claims data and places all hospitals on a comparable basis.

"Base year standardized costs per day" reflects the statewide average hospital costs per day for per diem cases in the base year. The standardization process removes the effects of regional variations in wages from the claims data and places all hospitals on a comparable basis. Base year standardized costs per day were calculated separately, but using the same calculation methodology, for the different types of per diem cases identified in this subsection under the definition of "per diem cases."

"Cost" means allowable cost as defined in Supplement 3 (12VAC30-70-10 through 12VAC30-70-130) and by Medicare principles of reimbursement.

"Disproportionate share hospital" means a hospital that meets the following criteria:

1. A Medicaid utilization rate in excess of ~~15%~~ 14%, or a low-income patient utilization rate exceeding 25% (as defined in the Omnibus Budget Reconciliation Act of 1987 and as amended by the Medicare Catastrophic Coverage Act of 1988); and

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

3. Subdivision 2 of this definition does not apply to a hospital:

a. At which the inpatients are predominantly individuals under 18 years of age; or

b. Which does not offer nonemergency obstetric services as of December 21, 1987.

"DRG cases" means medical/surgical cases subject to payment on the basis of DRGs. DRG cases do not include per diem cases.

"DRG relative weight" means the average standardized costs for cases assigned to that DRG divided by the average standardized costs for cases assigned to all DRGs.

"Groupable cases" means DRG cases having coding data of sufficient quality to support DRG assignment.

"Hospital case-mix index" means the weighted average DRG relative weight for all cases occurring at that hospital.

"Medicaid utilization percentage" is equal to the hospital's total Medicaid inpatient days divided by the hospital's total inpatient days for a given hospital fiscal year. The Medicaid utilization percentage includes days associated with inpatient hospital services provided to Medicaid patients but reimbursed by capitated managed care providers. This definition includes all paid Medicaid days (from DMAS MR reports for fee-for-service days and managed care organization or hospital reports for HMO days) and nonpaid/denied Medicaid days to include medically unnecessary days, inappropriate level of care service days, and days that exceed any maximum day limits (with appropriate documentation). The definition of Medicaid days does not include any general assistance, Family Access to Medical Insurance Security (FAMIS), State and Local Hospitalization (SLH), charity care, low-income, indigent care, uncompensated care, bad debt, or Medicare dually eligible days. It does not include days for newborns not enrolled in Medicaid during the fiscal year even though the mother was Medicaid eligible during the birth.

"Medicare wage index" and the "Medicare geographic adjustment factor" are published annually in the Federal Register by the Health Care Financing Administration. The indices and factors used in this article shall be those in effect in the base year.

"Operating cost-to-charge ratio" equals the hospital's total operating costs, less any applicable operating costs for a psychiatric DPU, divided by the hospital's total charges, less any applicable charges for a psychiatric DPU. The operating cost-to-charge ratio shall be calculated using data from cost reports from hospital fiscal years ending in the state fiscal year used as the base year.

"Outlier adjustment factor" means a fixed factor published annually in the Federal Register by the Health Care Financing Administration. The factor used in this article shall be the one in effect in the base year.

"Outlier cases" means those DRG cases, including transfer cases, in which the hospital's adjusted operating cost for the case exceeds the hospital's operating outlier threshold for the case.

"Outlier operating fixed loss threshold" means a fixed dollar amount applicable to all hospitals that shall be calculated in the base year so as to result in an expenditure for outliers operating payments equal to 5.1% of total operating payments for DRG cases. The threshold shall be updated in subsequent years using the same inflation values applied to hospital rates.

"Per diem cases" means cases subject to per diem payment and include (i) covered psychiatric cases in general acute care hospitals and distinct part units (DPUs) of general acute care hospitals (hereinafter "acute care psychiatric cases"), (ii) covered psychiatric cases in freestanding psychiatric facilities licensed as hospitals (hereinafter "freestanding psychiatric cases"), and (iii) rehabilitation cases in general acute care hospitals and rehabilitation hospitals (hereinafter "rehabilitation cases").

"Psychiatric cases" means cases with a principal diagnosis that is a mental disorder as specified in the ICD-9-CM. Not all mental disorders are covered. For coverage information, see Amount, Duration, and Scope of Services, Supplement 1 to Attachment 3.1 A & B (12VAC30-50-95 through 12VAC30-50-310). The limit of coverage of 21 days in a 60-day period for the same or similar diagnosis shall continue to apply to adult psychiatric cases.

"Psychiatric operating cost-to-charge ratio" for the psychiatric DPU of a general acute care hospital means the hospital's operating costs for a psychiatric DPU divided by the hospital's charges for a psychiatric DPU. In the base year, this ratio shall be calculated as described in the definition of "operating cost-to-charge ratio" in this subsection, using data from psychiatric DPUs.

"Readmissions" occur when patients are readmitted to the same hospital for the same or a similar diagnosis within five days of discharge. Such cases shall be considered a continuation of the same stay and shall not be treated as a new case. Similar diagnoses shall be defined as ICD-9-CM diagnosis codes possessing the same first three digits.

"Rehabilitation operating cost-to-charge ratio" for a rehabilitation unit or hospital means the provider's operating costs divided by the provider's charges. In the base year, this ratio shall be calculated as described in the definition of "operating cost-to-charge ratio" in this subsection, using data from rehabilitation units or hospitals.

"Statewide average labor portion of operating costs" means a fixed percentage applicable to all hospitals. The percentage shall be periodically revised using the most recent reliable data from the Virginia Health Information (VHI), or its successor.

"Transfer cases" means DRG cases involving patients (i) who are transferred from one general acute care hospital to another for related care or (ii) who are discharged from one general acute care hospital and admitted to another for the same or a similar diagnosis within five days of that discharge. Similar diagnoses shall be defined as ICD-9-CM diagnosis codes possessing the same first three digits.

"Type One" hospitals means those hospitals that were state-owned teaching hospitals on January 1, 1996. "Type Two" hospitals means all other hospitals.

"Ungroupable cases" means cases assigned to DRG 469 (principal diagnosis invalid as discharge diagnosis) and DRG 470 (ungroupable) as determined by the AP-DRG Grouper.

D. The All Patient Diagnosis Related Groups (AP-DRG) Grouper shall be used in the DRG payment system. Until notification of a change is given, Version 14.0 of this grouper

shall be used. DMAS shall notify hospitals when updating the system to later grouper versions.

E. Effective January 1, 2010, DRG cases shall be grouped based on the exclusion of Hospital Acquired Conditions (HAC) as published by Medicare periodically. HACs shall be defined using the criteria published by Medicare in the Federal Register (73 FR 48471-48491 (August 19, 2008)). Any significant changes to the Medicare list of conditions shall be implemented each January 1.

F. The primary data sources used in the development of the DRG payment methodology were the department's hospital computerized claims history file and the cost report file. The claims history file captures available claims data from all enrolled, cost-reporting general acute care hospitals, including Type One hospitals. The cost report file captures audited cost and charge data from all enrolled general acute care hospitals, including Type One hospitals. The following table identifies key data elements that were used to develop the DRG payment methodology and that will be used when the system is recalibrated and rebased.

Data Elements for DRG Payment Methodology	
Data Elements	Source
Total charges for each groupable case	Claims history file
Number of groupable cases in each DRG	Claims history file
Total number of groupable cases	Claims history file
Total charges for each DRG case	Claims history file
Total number of DRG cases	Claims history file
Total charges for each acute care psychiatric case	Claims history file
Total number of acute care psychiatric days for each acute care hospital	Claims history file
Total charges for each freestanding psychiatric case	Medicare cost reports
Total number of psychiatric days for each freestanding psychiatric hospital	Medicare cost reports
Total charges for each rehabilitation case	Claims history file
Total number of rehabilitation days for each acute care and freestanding rehabilitation hospital	Claims history file
Operating cost-to-charge ratio for each hospital	Cost report file
Operating cost-to-charge ratio for each freestanding psychiatric facility licensed as a hospital	Medicare cost reports
Psychiatric operating cost-to-charge ratio for the psychiatric DPU of each general acute care hospital	Cost report file
Rehabilitation cost-to-charge ratio for each rehabilitation unit or hospital	Cost report file
Statewide average labor portion of operating costs	VHI
Medicare wage index for each hospital	Federal Register
Medicare geographic adjustment factor for each hospital	Federal Register
Outlier operating fixed loss threshold	Claims history file
Outlier adjustment factor	Federal Register

12VAC30-70-291. Payment for indirect medical education costs.

A. Hospitals shall be eligible to receive payments for indirect medical education. Out-of-state cost reporting hospitals are eligible for this payment only if they have Virginia Medicaid utilization in the base year of at least 12% of total Medicaid days. These payments recognize the increased use of ancillary services associated with the educational process and the higher case-mix intensity of teaching hospitals. The payments for indirect medical education shall be made in estimated quarterly lump sum amounts and settled at the hospital's fiscal year end.

B. Final payment for IME shall be determined as follows:

1. Type One hospitals shall receive an IME payment equal to the hospital's Medicaid operating reimbursement times an IME percentage determined as follows:

IME Percentage for Type One Hospitals = [1.89 X ((1 + r)$^{0.405}$-1)] X (IME Factor)

An IME factor shall be calculated for each Type One hospital and shall equal a factor that, when used in the calculation of the IME percentage, shall cause the resulting IME payments to equal what the IME payments would be with an IME factor of one, plus an amount equal to the difference between operating payments using the adjustment factor specified in subdivision B 1 of 12VAC30-70-331 and operating payments using an adjustment factor of one in place of the adjustment factor specified in subdivision B 1 of 12VAC30-70-331.

2. Type Two hospitals shall receive an IME payment equal to the hospital's Medicaid operating reimbursement times an IME percentage determined as follows:

IME Percentage for Type Two Hospitals = [1.89 X ((1 + r)$^{0.405}$-1)] X 0.5695

In both equations, r is the ratio of full-time equivalent residents to staffed beds, excluding nursery beds. The IME payment shall be calculated each year using the most recent reliable data regarding the number of full-time equivalent residents and the number of staffed beds, excluding nursery beds.

C. An additional IME payment shall be made for inpatient hospital services provided to Medicaid patients but reimbursed by capitated managed care providers. This payment shall be equal to the hospital's hospital specific operating rate per case, as determined in 12VAC30-70-311, times the hospital's HMO paid discharges times the hospital's IME percentage, as determined in subsection B of this section.

D. An additional IME payment not to exceed ~~$1.5 million~~ $1.9 million in total shall be apportioned among Type Two Hospitals with Medicaid NICU utilization in excess of 50% and with overall Medicaid utilization in excess of 50% as reported to the Department of Medical Assistance Services as of March 1, 2004. These payments shall be apportioned based on each eligible hospital's percentage of Medicaid NICU patient days relative to the total of these days among eligible hospitals as reported by March 1, 2004.

~~E. An additional IME payment not to exceed $500,000 in total shall be apportioned among Type Two Hospitals with Medicaid NICU days in excess of 4,500 as reported to the Department of Medical Assistance Services as of March 1, 2005, that do not otherwise receive an additional IME payment under subsection D of this section. These payments shall be apportioned based on each eligible hospital's percentage of Medicaid NICU patient days relative to the total of these days among eligible hospitals as reported by March 1, 2005.~~

12VAC30-70-301. Payment to disproportionate share hospitals.

A. Payments to disproportionate share hospitals (DSH) shall be prospectively determined in advance of the state fiscal year to which they apply. The payments shall be made on a quarterly basis, shall be final, and shall not be subject to settlement except when necessary due to the limit in subsection D of this section.

B. Hospitals qualifying under the ~~15%~~ 14% inpatient Medicaid utilization percentage shall receive a DSH payment based on the hospital's type and the hospital's Medicaid utilization percentage.

1. Type One hospitals shall receive a DSH payment equal to:

a. The sum of (i) the hospital's Medicaid utilization percentage in excess of 10.5%, times 17, times the hospital's Medicaid operating reimbursement, times 1.4433 and (ii) the hospital's Medicaid utilization percentage in excess of 21%, times 17, times the hospital's Medicaid operating reimbursement, times 1.4433.

b. Multiplied by the Type One hospital DSH Factor. The Type One hospital DSH factor shall equal a percentage that when applied to the DSH payment calculation yields a DSH payment equal to the total calculated using the methodology outlined in subdivision 1 a of this subsection using an adjustment factor of one in the calculation of operating payments rather than the adjustment factor specified in subdivision B 1 of 12VAC30-70-331.

2. Type Two hospitals shall receive a DSH payment equal to the sum of (i) the hospital's Medicaid utilization percentage in excess of 10.5%, times the hospital's Medicaid operating reimbursement, times 1.2074 and (ii) the hospital's Medicaid utilization percentage in excess of 21%, times the hospital's Medicaid operating reimbursement, times 1.2074. Out-of-state cost reporting hospitals with Virginia utilization in the base year of less than 12% of total Medicaid days shall receive 50% of the payment described in this subsection.

C. Hospitals qualifying under the 25% low-income patient utilization rate shall receive a DSH payment based on the hospital's type and the hospital's low-income utilization rate.

1. Type One hospitals shall receive a DSH payment equal to the product of the hospital's low-income utilization in excess of 25%, times 17, times the hospital's Medicaid operating reimbursement.

2. Type Two hospitals shall receive a DSH payment equal to the product of the hospital's low-income utilization in excess of 25%, times the hospital's Medicaid operating reimbursement.

3. Calculation of a hospital's low-income patient utilization percentage is defined in 42 USC § 1396r-4(b)(3).

D. No DSH payments shall exceed any applicable limitations upon such payments established by federal law or regulations and § 1923(g) of the Social Security Act.

E. Each hospital's eligibility for DSH payment and the amount of the DSH payment shall be calculated at the time of each rebasing using the most recent reliable utilization data and projected operating reimbursement data available. The utilization data used to determine eligibility for DSH payment and the amount of the DSH payment shall include days for Medicaid recipients enrolled in capitated managed care programs. In years when DSH payments are not rebased in the way described above, the previous year's amounts shall be adjusted for inflation.

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

F. Effective July 1, 2010, DSH payments shall be rebased for all hospitals with the final calculation reduced by a uniform percentage such that the expenditures in FY 2011 do not exceed expenditures in FY 2010 separately for Type One and Type Two hospitals. The reduction shall be calculated

after determination of eligibility. Payments determined in FY 2011 shall not be adjusted for inflation in FY 2012.

12VAC30-70-351. Updating rates for inflation.

Each July, the Virginia moving average values as compiled and published by Global Insight (or its successor), under contract with the department shall be used to update the base year standardized operating costs per case, as determined in 12VAC30-70-361, and the base year standardized operating costs per day, as determined in 12VAC30-70-371, to the midpoint of the upcoming state fiscal year. The most current table available prior to the effective date of the new rates shall be used to inflate base year amounts to the upcoming rate year. Thus, corrections made by Global Insight (or its successor), in the moving averages that were used to update rates for previous state fiscal years shall be automatically incorporated into the moving averages that are being used to update rates for the upcoming state fiscal year.

The inflation adjustment for hospital operating rates, disproportionate share hospitals (DSH) payments, and graduate medical education payments shall be eliminated for fiscal year (FY) 2010, with the exception of long stay hospitals. ~~This reduction will not be applicable to rebasing in FY 2011.~~

In FY 2011, hospital operating rates shall be rebased; however the 2008 base year costs shall only be increased 2.58% for inflation. For FY 2011 there shall be no inflation adjustment for graduate medical education (GME) or freestanding psychiatric facility rates. The inflation adjustment shall be eliminated for hospital operating rates, GME payments, and freestanding psychiatric facility rates for FY 2012.

12VAC30-70-391. Recalibration and rebasing policy.

A. The department recognizes that claims experience or modifications in federal policies may require adjustment to the DRG payment system policies provided in this part. The state agency shall recalibrate (evaluate and adjust the DRG relative weights and hospital case-mix indices) and rebase (review and update the base year standardized operating costs per case and the base year standardized operating costs per day) the DRG payment system at least every three years. Recalibration and rebasing shall be done in consultation with the Medicaid Hospital Payment Policy Advisory Council noted in 12VAC30-70-490. When rebasing is carried out, if new rates are not calculated before their required effective date, hospitals required to file cost reports and freestanding psychiatric facilities licensed as hospitals shall be settled at the new rates, for discharges on and after the effective date of those rates, at the time the hospitals' cost reports for the year in which the rates become effective are settled.

B. Effective July 1, 2009, rates for freestanding psychiatric facilities shall be rebased using 2005 cost data as the base year. Future rebasings shall be consistent with rebasing for all other hospitals.

C. Effective July 1, 2010, rates for freestanding psychiatric facilities shall not be rebased.

12VAC30-80-180. Establishment of rate per visit.

A. Effective for dates of services on and after July 1, 1991, the Department of Medical Assistance Services (DMAS) shall reimburse home health agencies (HHAs) at a flat rate per visit for each type of service rendered by HHAs (i.e., nursing, physical therapy, occupational therapy, speech-language pathology services, and home health aide services.) In addition, supplies left in the home and extraordinary transportation costs will be paid at specific rates.

B. Effective for dates of services on and after July 1, 1993, DMAS shall establish a flat rate for each level of service for HHAs by peer group. There shall be three peer groups: (i) the Department of Health's HHAs, (ii) non-Department of Health HHAs whose operating office is located in the Virginia portion of the Washington DC-MD-VA metropolitan statistical area, and (iii) non-Department of Health HHAs whose operating office is located in the rest of Virginia. The use of the Health Care Financing Administration (HCFA) designation of urban metropolitan statistical areas (MSAs) shall be incorporated in determining the appropriate peer group for these classifications.

The Department of Health's agencies are being placed in a separate peer group due to their unique cost characteristics (only one consolidated cost report is filed for all Department of Health agencies).

C. Rates shall be calculated as follows:

1. Each home health agency shall be placed in its appropriate peer group.

2. Department of Health HHAs' Medicaid cost per visit (exclusive of medical supplies costs) shall be obtained from its 1989 cost-settled Medicaid cost report. Non-Department of Health HHAs' Medicaid cost per visit (exclusive of medical supplies costs) shall be obtained from the 1989 cost-settled Medicaid Cost Reports filed by freestanding HHAs. Costs shall be inflated to a common point in time (June 30, 1991) by using the percent of change in the moving average factor of the Data Resources Inc., (DRI), National Forecast Tables for the Home Health Agency Market Basket (as published quarterly).

3. To determine the flat rate per visit effective July 1, 1993, the following methodology shall be utilized:

a. The peer group HHA's per visit rates shall be ranked and weighted by the number of Medicaid visits per discipline to determine a median rate per visit for each peer group at July 1, 1991.

b. The HHA's peer group median rate per visit for each peer group at July 1, 1991, shall be the interim peer group rate for calculating the update through January 1, 1992. The interim peer group rate shall be updated by 100% of historical inflation from July 1, 1991, through December 31, 1992, and shall become the final interim peer group rate which shall be updated by 50% of the forecasted inflation to the end of December 31, 1993, to establish the final peer group rates. The lower of the final peer group rates or the Medicare upper limit at January 1, 1993, will be effective for payments from July 1, 1993, through December 1993.

c. Separate rates shall be provided for the initial assessment, follow-up, and comprehensive visits for skilled nursing and for the initial assessment and follow-up visits for physical therapy, occupational therapy, and speech therapy. The comprehensive rate shall be 200% of the follow-up rate, and the initial assessment rates shall be $15 higher than the follow-up rates. The lower of the peer group median or Medicare upper limits shall be adjusted as appropriate to assure budget neutrality when the higher rates for the comprehensive and initial assessment visits are calculated.

4. The fee schedule shall be adjusted annually beginning July 1, 2010, based on the percent of change in the moving average of the National Forecast Tables for the Home Health Agency Market Basket published by Global Insight (or its successor) for the second quarter of the calendar year in which the fiscal year begins. The report shall be the latest published report prior to the fiscal year. The method to calculate the annual update shall be:

a. All subsequent year peer group rates shall be calculated utilizing the previous final peer group rate established on July 1.

b. The annual July 1 update shall be compared to the Medicare upper limit per visit in effect on each January 1, and the HHA's shall receive the lower of the annual update or the Medicare upper limit per visit as the final peer group rate.

D. Effective July 1, 2009, the previous inflation increase effective January 1, 2009, shall be reduced by 50%.

E. Effective July 1, 2010, through June 30, 2012, there shall be no inflation adjustment for home health agencies.

12VAC30-80-190. State agency fee schedule for RBRVS.

A. Reimbursement of fee-for-service providers. Effective for dates of service on or after July 1, 1995, the Department of Medical Assistance Services (DMAS) shall reimburse fee-for-service providers, with the exception of home health services (see 12VAC30-80-180) and durable medical equipment services (see 12VAC30-80-30), using a fee schedule that is based on a Resource Based Relative Value Scale (RBRVS).

B. Fee schedule.

1. For those services or procedures which are included in the RBRVS published by the Centers for Medicare and Medicaid Services (CMS) as amended from time to time, DMAS' fee schedule shall employ the Relative Value Units (RVUs) developed by CMS as periodically updated.

a. Effective for dates of service on or after July 1, 2008, DMAS shall implement site of service differentials and employ both nonfacility and facility RVUs. The implementation shall be budget neutral using the methodology in subdivision 2 of this subsection.

b. The implementation of site of service shall be transitioned over a four-year period.

(1) Effective for dates of service on or after July 1, 2008, DMAS shall calculate the transitioned facility RVU by adding 75% of the difference between the nonfacility RVU and nonfacility RVU to the facility RVU.

(2) Effective for dates of service on or after July 1, 2009, DMAS shall calculate the transitioned facility RVU by adding 50% of the difference between the nonfacility RVU and nonfacility RVU to the facility RVU.

(3) Effective for dates of service on or after July 1, 2010, DMAS shall calculate the transitioned facility RVU by adding 25% of the difference between the nonfacility RVU and nonfacility RVU to the facility RVU.

(4) Effective for dates of service on or after July 1, 2011, DMAS shall use the unadjusted Medicare facility RVU.

2. DMAS shall calculate the RBRVS-based fees using conversion factors (CFs) published from time to time by CMS. DMAS shall adjust CMS' CFs by additional factors so that no change in expenditure will result solely from the implementation of the RBRVS-based fee schedule. DMAS may revise the additional factors when CMS updates its RVUs or CFs so that no change in expenditure will result solely from such updates. Except for this adjustment, DMAS' CFs shall be the same as those published from time to time by CMS. The calculation of the additional factors shall be based on the assumption that no change in services provided will occur as a result of these changes to the fee schedule. The determination of the additional factors required above shall be accomplished by means of the following calculation:

a. The estimated amount of DMAS expenditures if DMAS were to use Medicare's RVUs and CFs without modification, is equal to the sum, across all relevant procedure codes, of the RVU value published by the CMS, multiplied by the applicable conversion factor published by the CMS, multiplied by the number of

occurrences of the procedure code in DMAS patient claims in the most recent period of time (at least six months).

b. The estimated amount of DMAS expenditures, if DMAS were not to calculate new fees based on the new CMS RVUs and CFs, is equal to the sum, across all relevant procedure codes, of the existing DMAS fee multiplied by the number of occurrences of the procedures code in DMAS patient claims in the period of time used in subdivision 2 a of this subsection.

c. The relevant additional factor is equal to the ratio of the expenditure estimate (based on DMAS fees in subdivision 2 b of this subsection) to the expenditure estimate based on unmodified CMS values in subdivision 2 a of this subsection.

d. DMAS shall calculate a separate additional factor for:

(1) Emergency room services (defined as the American Medical Association's (AMA) publication of the Current Procedural Terminology (CPT) codes 99281, 99282, 99283, 99284, and 992851 in effect at the time the service is provided);

(2) Obstetrical/gynecological services (defined as maternity care and delivery procedures, female genital system procedures, obstetrical/gynecological-related radiological procedures, and mammography procedures, as defined by the American Medical Association's (AMA) publication of the Current Procedural Terminology (CPT) manual in effect at the time the service is provided);

(3) Pediatric preventive services (defined as preventive E&M procedures, excluding those listed in subdivision 2 d (1) of this subsection, as defined by the AMA's publication of the CPT manual, in effect at the time the service is provided, for recipients under age 21);

(4) Pediatric primary services (defined as evaluation and management (E&M) procedures, excluding those listed in subdivisions 2 d (1) and 2 d (3) of this subsection, as defined by the AMA's publication of the CPT manual, in effect at the time the service is provided, for recipients under age 21);

(5) Adult primary and preventive services (defined as E&M procedures, excluding those listed in subdivision 2 d (1) of this subsection, as defined by the AMA's publication of the CPT manual, in effect at the time the service is provided, for recipients age 21 and over); and

(6) All other procedures set through the RBRVS process combined.

3. For those services or procedures for which there are no established RVUs, DMAS shall approximate a reasonable relative value payment level by looking to similar existing relative value fees. If DMAS is unable to establish a relative value payment level for any service or procedure, the fee shall not be based on a RBRVS, but shall instead be based on the previous fee-for-service methodology.

4. Fees shall not vary by geographic locality.

5. Effective for dates of service on or after July 1, 2007, fees for emergency room services (defined in subdivision 2 d (1) of this subsection) shall be increased by 5.0% relative to the fees that would otherwise be in effect.

C. Effective for dates of service on or after May 1, 2006, fees for obstetrical/gynecological services (defined in subdivision B 2 d (2) of this section) shall be increased by 2.5% relative to the fees in effect on July 1, 2005.

D. Effective for dates of service on or after May 1, 2006, fees for pediatric services (defined in subdivisions B 2 d (3) and (4) of this section) shall be increased by 5.0% relative to the fees in effect on July 1, 2005. Effective for dates of service on or after July 1, 2006, fees for pediatric services (defined in subdivisions B 2 d (3) and (4) of this section) shall be increased by 5.0% relative to the fees in effect on May 1, 2006. Effective for dates of service on or after July 1, 2007, fees for pediatric primary services (defined in subdivision B 2 d (4) of this section) shall be increased by 10% relative to the fees that would otherwise be in effect.

E. Effective for dates of service on or after July 1, 2007, fees for pediatric preventive services (defined in subdivision B 2 d (3) of this section) shall be increased by 10% relative to the fees that would otherwise be in effect.

F. Effective for dates of service on or after May 1, 2006, fees for adult primary and preventive services (defined in subdivision B 2 d (4) of this section) shall be increased by 5.0% relative to the fees in effect on July 1, 2005. Effective for dates of service on or after July 1, 2007, fees for adult primary and preventive services (defined in subdivision B 2 d (5) of this section) shall be increased by 5.0% relative to the fees that would otherwise be in effect.

G. Effective for dates of service on or after July 1, 2007, fees for all other procedures set through the RBRVS process combined (defined in subdivision B 2 d (6) of this section) shall be increased by 5.0% relative to the fees that would otherwise be in effect.

H. Effective for dates of service on or after July 1, 2010, fees for all procedures set through the RBRVS process shall be decreased by 3.0% relative to the fees that would otherwise be in effect. However, if the increased federal medical assistance percentage under the American Recovery and Reinvestment Act (P.L. 111-5) is extended through June 30, 2011, as provided in Item 297 CCCC.3 of the 2010 Virginia Acts of Assembly, the reduction in this subsection shall not become effective.

I. Effective for dates of service on or after July 1, 2011, fees for all procedures set through the RBRVS process shall be decreased by 4.0% relative to the fees that would have been in effect except for the provisions of subsection H of this section. However, if the increased federal medical assistance percentage under the American Recovery and Reinvestment Act (P.L. 111-5) is extended through June 30, 2011, as provided in Item 297 CCCC.3 of the 2010 Virginia Acts of Assembly, the reduction in this subsection shall not become effective.

12VAC30-80-200. Prospective reimbursement for rehabilitation agencies.

A. Effective for dates of service on and after July 1, 2009, rehabilitation agencies, excluding those operated by community services boards and state agencies, shall be reimbursed a prospective rate equal to the lesser of the agency's fee schedule amount or billed charges per procedure. The agency shall develop a statewide fee schedule based on CPT codes to reimburse providers what the agency estimates they would have been paid in FY 2010 minus $371,800.

B. For providers with fiscal years that do not begin on July 1, 2009, services on or before June 30, 2009, for the fiscal year in progress on that date shall be settled based on the previous prospective rate methodology and the ceilings in effect for that fiscal year as of June 30, 2009.

C. Rehabilitation services furnished by community service boards or state agencies shall be reimbursed costs based on annual cost reporting methodology and procedures.

D. Beginning with state fiscal years beginning on or after July 1, 2010, rates shall be adjusted annually for inflation using the Virginia-specific nursing home input price index contracted for by the agency. The agency shall use the percent moving average for the quarter ending at the midpoint of the rate year from the most recently available index prior to the beginning of the rate year.

E. Effective July 1, 2010, there will be no inflation adjustment for outpatient rehabilitation facilities through June 30, 2012.

12VAC30-90-41. Nursing facility reimbursement formula.

A. Effective on and after July 1, 2002, all NFs subject to the prospective payment system shall be reimbursed under "The Resource Utilization Group-III (RUG-III) System as defined in Appendix IV (12VAC30-90-305 through 12VAC30-90-307)." RUG-III is a resident classification system that groups NF residents according to resource utilization. Case-mix indices (CMIs) are assigned to RUG-III groups and are used to adjust the NF's per diem rates to reflect the intensity of services required by a NF's resident mix. See 12VAC30-90-305 through 12VAC30-90-307 for details on the Resource Utilization Groups.

1. Any NF receiving Medicaid payments on or after October 1, 1990, shall satisfy all the requirements of § 1919(b) through (d) of the Social Security Act as they relate to provision of services, residents' rights and administration and other matters.

2. Direct and indirect group ceilings and rates.

a. In accordance with 12VAC30-90-20 C, direct patient care operating cost peer groups shall be established for the Virginia portion of the Washington DC-MD-VA MSA, the Richmond-Petersburg MSA and the rest of the state. Direct patient care operating costs shall be as defined in 12VAC30-90-271.

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

3. Each facility's average case-mix index shall be calculated based upon data reported by that nursing facility to the Centers for Medicare and Medicaid Services (CMS) (formerly HCFA) Minimum Data Set (MDS) System. See 12VAC30-90-306 for the case-mix index calculations.

4. The normalized facility average Medicaid CMI shall be used to calculate the direct patient care operating cost prospective ceilings and direct patient care operating cost prospective rates for each semiannual period of a NFs subsequent fiscal year. See 12VAC30-90-306 D 2 for the calculation of the normalized facility average Medicaid CMI.

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

b. A CMI rate adjustment for each semiannual period of a nursing facility's prospective fiscal year shall be applied by multiplying the nursing facility's normalized facility average Medicaid CMI applicable to each prospective semiannual period by the nursing facility's case-mix neutralized direct patient care operating cost base rate for the preceding cost reporting period (see 12VAC30-90-307).

c. See 12VAC30-90-307 for the applicability of case-mix indices.

5. Direct and indirect ceiling calculations.

a. Effective for services on and after July 1, 2006, the direct patient care operating ceiling shall be set at 117% of the respective peer group day-weighted median of the facilities' case-mix neutralized direct care operating costs

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

b. The indirect patient care operating ceiling shall be set at 107% of the respective peer group day-weighted median of the facility's specific indirect operating cost per day. The calculation of the peer group medians shall be based on cost reports from freestanding nursing homes for provider fiscal years ending in the most recent base year. The medians used to set the peer group indirect operating ceilings shall be revised every two years using the most recent reliable calendar year cost settled cost reports for freestanding nursing facilities that have been completed as of September 1.

6. Reimbursement for use of specialized treatment beds. Effective for services on and after July 1, 2005, nursing facilities shall be reimbursed an additional $10 per day for those recipients who require a specialized treatment bed due to their having at least one Stage IV pressure ulcer. Recipients must meet criteria as outlined in 12VAC30-60-350, and the additional reimbursement must be preauthorized as provided in 12VAC30-60-40. Nursing facilities shall not be eligible to receive this reimbursement for individuals whose services are reimbursed under the specialized care methodology. Beginning July 1, 2005, this additional reimbursement shall be subject to adjustment for inflation in accordance with 12VAC30-90-41 B, except that the adjustment shall be made at the beginning of each state fiscal year, using the inflation factor that applies to provider years beginning at that time. This additional payment shall not be subject to direct or indirect ceilings and shall not be adjusted at year-end settlement.

B. Adjustment of ceilings and costs for inflation. Effective for provider fiscal years starting on and after July 1, 2002, ceilings and rates shall be adjusted for inflation each year using the moving average of the percentage change of the Virginia-Specific Nursing Home Input Price Index, updated quarterly, published by Standard & Poor's DRI. For state fiscal year 2003, peer group ceilings and rates for indirect costs will not be adjusted for inflation.

1. For provider years beginning in each calendar year, the percentage used shall be the moving average for the second quarter of the year, taken from the table published for the fourth quarter of the previous year. For example, in setting prospective rates for all provider years beginning in January through December 2002, ceilings and costs would be inflated using the moving average for the second quarter of 2002, taken from the table published for the fourth quarter of 2001.

2. Provider specific costs shall be adjusted for inflation each year from the cost reporting period to the prospective rate period using the moving average as specified in subdivision 1 of this subsection. If the cost reporting period or the prospective rate period is less than 12 months long, a fraction of the moving average shall be used that is equal to the fraction of a year from the midpoint of the cost reporting period to the midpoint of the prospective rate period.

3. Ceilings shall be adjusted from the common point established in the most recent rebasing calculation. Base period costs shall be adjusted to this common point using moving averages from the DRI tables corresponding to the provider fiscal period, as specified in subdivision 1 of this subsection. Ceilings shall then be adjusted from the common point to the prospective rate period using the moving average(s) for each applicable second quarter, taken from the DRI table published for the fourth quarter of the year immediately preceding the calendar year in which the prospective rate years begin. Rebased ceilings shall be effective on July 1 of each rebasing year, so in their first application they shall be adjusted to the midpoint of the provider fiscal year then in progress or then beginning. Subsequently, they shall be adjusted each year from the common point established in rebasing to the midpoint of the appropriate provider fiscal year. For example, suppose the base year is made up of cost reports from years ending in calendar year 2000, the rebasing year is SFY2003, and the rebasing calculation establishes ceilings that are inflated to the common point of July 1, 2002. Providers with years in progress on July 1, 2002, would receive a ceiling effective July 1, 2002, that would be adjusted to the midpoint of the provider year then in progress. In some cases this would mean the ceiling would be reduced from the July 1, 2002, ceiling level. The following table shows the application of these provisions for different provider fiscal periods.

Table I
Application of Inflation to Different Provider Fiscal Periods

Provider FYE	Effective Date of New Ceiling	First PFYE After Rebasing Date	Inflation Time Span from Ceiling Date to Midpoint of First PFY	Second PFYE After Re-basing Date	Inflation Time Span from Ceiling Date to Midpoint of Second PFY
3/31	7/1/02	3/31/03	+ 1/4 year	3/31/04	+1-1/4 years
6/30	7/1/02	6/30/03	+ 1/2 year	6/30/04	+ 1-1/2 years
9/30	7/1/02	9/30/02	- 1/4 year	9/30/03	+ 3/4 years

12/31	7/1/02	12/31/02	-0-	12/31/03	+1 year

The following table shows the DRI tables that would provide the moving averages for adjusting ceilings for different prospective rate years.

Table II
Source Tables for DRI Moving Average Values

Provider FYE	Effective Date of New Ceiling	First PFYE After Rebasing Date	Source DRI Table for First PFY Ceiling Inflation	Second PFYE After Re-basing Date	Source DRI Table for Second PFY Ceiling Inflation
3/31	7/1/02	3/31/03	Fourth Quarter 2001	3/31/04	Fourth Quarter 2002
6/30	7/1/02	6/30/03	Fourth Quarter 2001	6/30/04	Fourth Quarter 2002
9/30	7/1/02	9/30/02	Fourth Quarter 2000	9/30/03	Fourth Quarter 2001
12/31	7/1/02	12/31/02	Fourth Quarter 2000	12/31/03	Fourth Quarter 2001

In this example, when ceilings are inflated for the second PFY after the rebasing date, the ceilings will be inflated from July 1, 2002, using moving averages from the DRI table specified for the second PFY. That is, the ceiling for years ending June 30, 2004, will be the June 30, 2002, base period ceiling, adjusted by 1/2 of the moving average for the second quarter of 2002, compounded with the moving average for the second quarter of 2003. Both these moving averages will be taken from the fourth quarter 2002 DRI table.

C. The RUG-III Nursing Home Payment System shall require comparison of the prospective operating cost rates to the prospective operating ceilings. The provider shall be reimbursed the lower of the prospective operating cost rate or prospective operating ceiling.

D. Nonoperating costs. Plant or capital, as appropriate, costs shall be reimbursed in accordance with Articles 1, 2, and 3 of this subpart. Plant costs shall not include the component of cost related to making or producing a supply or service.

NATCEPs cost shall be reimbursed in accordance with 12VAC30-90-170.

E. The prospective rate for each NF shall be based upon operating cost and plant/capital cost components or charges, whichever is lower, plus NATCEPs costs. The disallowance of nonreimbursable operating costs in any current fiscal year shall be reflected in a subsequent year's prospective rate determination. Disallowances of nonreimbursable plant or capital, as appropriate, costs and NATCEPs costs shall be reflected in the year in which the nonreimbursable costs are included.

F. Effective July 1, 2001, for those NFs whose indirect operating cost rates are below the ceilings, an incentive plan shall be established whereby a NF shall be paid, on a sliding scale, up to 25% of the difference between its allowable indirect operating cost rates and the indirect peer group ceilings.

1. The following table presents four incentive examples:

Peer Group Ceilings	Allowable Cost Per Day	Difference	% of Ceiling	Sliding Scale	Scale % Difference
$30.00	$27.00	$3.00	10%	$0.30	10%
30.00	22.50	7.50	25%	1.88	25%
30.00	20.00	10.00	33%	2.50	25%
30.00	30.00	0	0		

2. Efficiency incentives shall be calculated only for the indirect patient care operating ceilings and costs. Effective July 1, 2001, a direct care efficiency incentive shall no longer be paid.

G. Quality of care requirement. A cost efficiency incentive shall not be paid for the number of days for which a facility is out of substantial compliance according to the Virginia Department of Health survey findings as based on federal regulations.

H. Sale of facility. In the event of the sale of a NF, the prospective base operating cost rates for the new owner's first fiscal period shall be the seller's prospective base operating cost rates before the sale.

I. Public notice. To comply with the requirements of § 1902(a)(28)(c) of the Social Security Act, DMAS shall make available to the public the data and methodology used in establishing Medicaid payment rates for nursing facilities. Copies may be obtained by request under the existing procedures of the Virginia Freedom of Information Act.

J. Effective July 1, 2005, the total per diem payment to each nursing home shall be increased by $3.00 per day. This increase in the total per diem payment shall cease effective July 1, 2006. Effective July 1, 2006, when cost data that include time periods before July 1, 2005, are used to set facility specific rates, a portion of the $3.00 per day amount identified above, based on the percentage of patient days in the provider's cost reporting period that fall before July 1, 2005, adjusted for appropriate inflation and multiplied times the provider's Medicaid utilization rate, shall be allocated to the facility specific direct and indirect cost per day prior to comparison to the peer group ceilings. For purposes of this subsection, $1.68 of the $3.00 shall be considered direct costs and $1.32 of the $3.00 shall be considered indirect costs.

K. Effective July 1, 2008, and ending after June 30, 2009, the operating rate for nursing facilities shall be reduced by 1.329%.

L. Effective July 1, 2009, through June 30, 2010, there will be no inflation adjustment for nursing facility operating rates and ceilings and specialized care operating rates and ceilings. Exempt from this are government-owned nursing facilities with Medicaid utilization of 85% or greater in provider fiscal year 2007.

M. Effective July 1, 2010, through June 30, 2012, there shall be no inflation adjustment for nursing facility and specialized care operating rates. Nursing facility and specialized care ceilings shall freeze at the same level as the ceilings for nursing facilities with provider fiscal year ends of June 30, 2010.

VA.R. Doc. No. R10-2387; Filed May 6, 2010, 12:50 p.m.

Final Regulation

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

Title of Regulation: **12VAC30-80. Methods and Standards for Establishing Payment Rates; Other Types of Care (amending 12VAC30-80-40).**

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

Effective Date: July 1, 2010.

Agency Contact: Brian McCormick, Regulatory Supervisor, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-8856, FAX (804) 786-1680, or email brian.mccormick@dmas.virginia.gov.

Summary:

This amendment is required to comply with Item 297 SSS of the 2010 Virginia Appropriation Act, which requires DMAS to amend the State Plan for Medical Assistance to decrease the maximum reimbursement for pharmaceutical products from the current pricing methodology of the estimated acquisition cost equaling the Average Wholesale Price (AWP) minus 10.25%, to a methodology in which the estimated acquisition cost is equal to the AWP minus 13.1%. This budget reduction in pharmacy reimbursement is dependent upon the unavailability of enhanced federal match dollars provided for in the American Recovery and Reinvestment Act (ARRA - P.L. 111-5). The increased federal Medicaid payments to the states under ARRA run out in December 2010. Congress currently is considering extending the enhanced federal Medicaid payments to the states through June 30, 2011. If Congress extends the increased federal match percentage, Virginia will not implement this budget reduction measure. If, however, Congress does not extend the ARRA enhanced percentage, DMAS must implement this reduction in pharmacy reimbursement effective July 1, 2010.

12VAC30-80-40. Fee-for-service providers: pharmacy.

Payment for pharmacy services shall be the lowest of items 1 through 5 (except that items 1 and 2 will not apply when prescriptions are certified as brand necessary by the prescribing physician in accordance with the procedures set forth in 42 CFR 447.512(c) if the brand cost is greater than the Centers for Medicare and Medicaid Services (CMS) upper limit of VMAC cost) subject to the conditions, where applicable, set forth in subdivisions 6 and 7 of this section:

1. The upper limit established by the CMS for multiple source drugs pursuant to 42 CFR 447.512 and 447.514, as determined by the CMS Upper Limit List plus a dispensing fee. If the agency provides payment for any drugs on the HCFA Upper Limit List, the payment shall be subject to the aggregate upper limit payment test.

2. The methodology used to reimburse for generic drug products shall be the higher of either (i) the lowest Wholesale Acquisition Cost (WAC) plus 10% or (ii) the second lowest WAC plus 6.0%. This methodology shall reimburse for products' costs based on a Maximum Allowable Cost (VMAC) list to be established by the single state agency.

a. In developing the maximum allowable reimbursement rate for generic pharmaceuticals, the department or its designated contractor shall:

(1) Identify three different suppliers, including manufacturers that are able to supply pharmaceutical products in sufficient quantities. The drugs considered must be listed as therapeutically and pharmaceutically equivalent in the Food and Drug Administration's most recent version of the Approved Drug Products with Therapeutic Equivalence Evaluations (Orange Book). Pharmaceutical products that are not available from three different suppliers, including manufacturers, shall not be subject to the VMAC list.

(2) Identify that the use of a VMAC rate is lower than the Federal Upper Limit (FUL) for the drug. The FUL is a known, widely published price provided by CMS; and

(3) Distribute the list of state VMAC rates to pharmacy providers in a timely manner prior to the implementation of VMAC rates and subsequent modifications. DMAS

shall publish on its website, each month, the information used to set the Commonwealth's prospective VMAC rates, including, but not necessarily limited to:

(a) The identity of applicable reference products used to set the VMAC rates;

(b) The Generic Code Number (GCN) or National Drug Code (NDC), as may be appropriate, of reference products;

(c) The difference by which the VMAC rate exceeds the appropriate WAC price; and

(d) The identity and date of the published compendia used to determine reference products and set the VMAC rate. The difference by which the VMAC rate exceeds the appropriate WAC price shall be at least or equal to 10% above the lowest-published wholesale acquisition cost for products widely available for purchase in the Commonwealth and shall be included in national pricing compendia.

b. Development of a VMAC rate that does not have a FUL rate shall not result in the use of higher-cost innovator brand name or single source drugs in the Medicaid program.

c. DMAS or its designated contractor shall:

(1) Implement and maintain a procedure to add or eliminate products from the list, or modify VMAC rates, consistent with changes in the fluctuating marketplace. DMAS or its designated contractor will regularly review manufacturers' pricing and monitor drug availability in the marketplace to determine the inclusion or exclusion of drugs on the VMAC list; and

(2) Provide a pricing dispute resolution procedure to allow a dispensing provider to contest a listed VMAC rate. DMAS or its designated contractor shall confirm receipt of pricing disputes within 24 hours, via telephone or facsimile, with the appropriate documentation of relevant information, e.g., invoices. Disputes shall be resolved within three business days of confirmation. The pricing dispute resolution process will include DMAS' or the contractor's verification of accurate pricing to ensure consistency with marketplace pricing and drug availability. Providers will be reimbursed, as appropriate, based on findings. Providers shall be required to use this dispute resolution process prior to exercising any applicable appeal rights.

3. The provider's usual and customary charge to the public, as identified by the claim charge.

4. The Estimated Acquisition Cost (EAC), which shall be based on the published Average Wholesale Price (AWP) minus a percentage discount established by the General Assembly (as set forth in subdivision 8 of this section) or, in the absence thereof, by the following methodology set out in subdivisions a through c of this subdivision.

a. Percentage discount shall be determined by a statewide survey of providers' acquisition cost.

b. The survey shall reflect statistical analysis of actual provider purchase invoices.

c. The agency will conduct surveys at intervals deemed necessary by DMAS.

5. MAC methodology for specialty drugs. Payment for drug products designated by DMAS as specialty drugs shall be the lesser of subdivisions 1 through 4 of this section or the following method, whichever is least:

a. The methodology used to reimburse for designated specialty drug products shall be the WAC price plus the WAC percentage. The WAC percentage is a constant percentage identified each year for all GCNs.

b. Designated specialty drug products are certain products used to treat chronic, high-cost, or rare diseases; the drugs subject to this pricing methodology and their current reimbursement rates are listed on the DMAS website at the following internet address: http://www.dmas.virginia.gov/downloads/pdfs/pharm-special_mac_list.pdf.

c. The MAC reimbursement methodology for specialty drugs shall be subject to the pricing review and dispute resolution procedures described in subdivisions 2 c (1) and 2 c (2) of this section.

6. Payment for pharmacy services will be as described above; however, payment for legend drugs will include the allowed cost of the drug plus only one dispensing fee per month for each specific drug. Exceptions to the monthly dispensing fees shall be allowed for drugs determined by the department to have unique dispensing requirements. The dispensing fee for brand name and generic drugs is $3.75.

7. The Program pays additional reimbursement for unit dose dispensing systems of dispensing drugs. DMAS defines its unit dose dispensing system coverage consistent with that of the Board of Pharmacy of the Department of Health Professions (18VAC110-20-420). This service is paid only for patients residing in nursing facilities. Reimbursements are based on the allowed payments described above plus the unit dose per capita fee to be calculated by DMAS' fiscal agent based on monthly per nursing home resident service per pharmacy provider. Only one service fee per month may be paid to the pharmacy for each patient receiving unit dose dispensing services. Multisource drugs will be reimbursed at the maximum allowed drug cost for specific multiple source drugs as identified by the state agency or CMS' upper limits as applicable. All other drugs will be reimbursed at drug costs

not to exceed the estimated acquisition cost determined by the state agency. The original per capita fee shall be determined by a DMAS analysis of costs related to such dispensing, and shall be reevaluated at periodic intervals for appropriate adjustment. The unit dose dispensing fee is $5.00 per recipient per month per pharmacy provider.

8. ~~Determination of EAC was the result of a report by the Office of the Inspector General that focused on appropriate Medicaid marketplace pricing of pharmaceuticals based on the documented costs to the pharmacy.~~ An EAC of AWP minus ~~10.25%~~ 13.1% shall become effective July 1, ~~2002~~ 2010. However, if the increased federal medical assistance percentage under the American Recovery and Reinvestment Act (P.L. 111-5) is extended through June 30, 2011, as provided in Item 297 SSS of the 2010 Acts of Assembly, the reduction shall remain at AWP minus 10.25%. The dispensing fee for brand name and generic drugs of $3.75 shall remain in effect, creating a payment methodology based on the previous algorithm (least of subdivisions of this section) plus a dispensing fee where applicable.

9. Home infusion therapy.

a. The following therapy categories shall have a pharmacy service day rate payment allowable: hydration therapy, chemotherapy, pain management therapy, drug therapy, total parenteral nutrition (TPN). The service day rate payment for the pharmacy component shall apply to the basic components and services intrinsic to the therapy category. Submission of claims for the per diem rate shall be accomplished by use of the CMS 1500 claim form.

b. The cost of the active ingredient or ingredients for chemotherapy, pain management and drug therapies shall be submitted as a separate claim through the pharmacy program, using standard pharmacy format. Payment for this component shall be consistent with the current reimbursement for pharmacy services. Multiple applications of the same therapy shall be reimbursed one service day rate for the pharmacy services. Multiple applications of different therapies shall be reimbursed at 100% of standard pharmacy reimbursement for each active ingredient.

10. Supplemental rebate agreement. Based on the requirements in § 1927 of the Social Security Act, the Commonwealth of Virginia has the following policies for the supplemental drug rebate program for Medicaid recipients:

a. The model supplemental rebate agreement between the Commonwealth and pharmaceutical manufacturers for legend drugs provided to Medicaid recipients, submitted to CMS on February 5, 2004, and entitled Virginia Supplemental Drug Rebate Agreement Contract A and Amendment #2 to Contract A has been authorized by CMS.

b. The model supplemental rebate agreement between the Commonwealth and pharmaceutical manufacturers for drugs provided to Medicaid recipients, submitted to CMS on February 5, 2004, and entitled Virginia Supplemental Drug Rebate Agreement Contract B and Amendment #2 to Contract B has been authorized by CMS.

c. The model supplemental rebate agreement between the Commonwealth and pharmaceutical manufacturers for drugs provided to Medicaid recipients, submitted to CMS on February 5, 2004, and entitled Virginia Supplemental Drug Rebate Agreement Contract C, and Amendments #1 and #2 to Contract C has been authorized by CMS.

d. Supplemental drug rebates received by the state in excess of those required under the national drug rebate agreement will be shared with the federal government on the same percentage basis as applied under the national drug rebate agreement.

e. Prior authorization requirements found in § 1927(d)(5) of the Social Security Act have been met.

f. Nonpreferred drugs are those that were reviewed by the Pharmacy and Therapeutics Committee and not included on the preferred drug list. Nonpreferred drugs will be made available to Medicaid beneficiaries through prior authorization.

g. Payment of supplemental rebates may result in a product's inclusion on the PDL.

VA.R. Doc. No. R10-2393; Filed May 3, 2010, 3:21 p.m.

Final Regulation

Title of Regulation: **12VAC30-135. Demonstration Waiver Services (amending 12VAC30-135-140).**

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

Effective Date: July 1, 2010.

Agency Contact: Brian McCormick, Regulatory Supervisor, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-8856, FAX (804) 786-1680, or email brian.mccormick@dmas.virginia.gov.

Summary:

This amendment is required to comply with Item 297 XX of the 2010 Virginia Appropriation Act, which requires that the Department of Medical Assistance Services amend the Children's Mental Health Program Waiver to permit a child to be evaluated as a separate assistance unit of one. The Centers for Medicare and Medicaid Services has approved the change in eligibility. This regulatory change allows children to be counted as a family of one when the

child is discharged from a Psychiatric Residential Treatment Facility (PRTF).

Currently, when a child is discharged from a PRTF, eligibility is based on the family's income. This may cause the child to lose Medicaid eligibility for community care and may result in the child remaining in the PRTF for a longer stay. The program only has about 25 children enrolled versus a projected 300. This change will result in more children being enrolled in the waiver and save the Commonwealth from having to pay the higher costs of a PRTF.

12VAC30-135-140. Client eligibility requirements and intake process.

A. Virginia will ~~apply the financial eligibility criteria contained in the State Plan for the categorically needy~~ evaluate clients for the CMH waiver as a separate assistance unit of one regardless of whether the child is living in the home with a parent or guardian, or siblings. Under this waiver, clients must meet the financial and nonfinancial Medicaid eligibility criteria and meet the PRTF institutional level-of-care criteria. DMAS shall be the single state agency authority responsible for the supervision and administration of the CMH waiver.

B. The following three criteria shall apply to all CMH waiver services:

1. Clients qualifying for CMH waiver services must have a demonstrated need for the service resulting in significant functional limitations. The need for the service must arise from the client having a SED and meeting the level-of-care for admission to a PRTF;

2. The services described in the ISP, and services as delivered, must be consistent with the Medicaid definition of each service; and

3. Services must be recommended based on a current assessment using a DMAS-approved assessment instrument and a client's demonstrated need for each specific service.

C. Assessment, screening, authorization and enrollment in home and community-based care services.

1. To ensure that Virginia's CMH waiver serves only clients who would otherwise remain in a PRTF, home and community-based care services shall be considered only for clients who have resided in a PRTF for at least 90 days to ensure that the client's condition has been stabilized. Home and community-based care services shall be the critical service that enables the client to be discharged home rather than remaining in a PRTF. Clients must receive at least one CMH waiver service to remain in the waiver.

2. CMH waiver services must be determined by DMAS or a DMAS-contracted entity to be an appropriate service alternative as defined in these regulations to remaining in a PRTF.

3. The client shall be recommended for CMH waiver services after completion of a comprehensive assessment of the client's needs and available supports. The completion of an assessment is mandatory before the client can be enrolled in the CMH waiver and Medicaid assumes payment responsibility for the waiver services.

4. The CMH waiver screener shall gather relevant medical, social, and psychological data and identify services to meet the client's needs in the community.

5. The client or family/caregiver, as appropriate, must be offered the choice of CMH waiver services or to remain in the PRTF. If the client chooses CMH waiver services, the client must also be offered the choice of waiver providers.

6. The screener shall explore alternative settings and services to provide the care needed by the client.

7. Medicaid will not pay for any home and community-based care services delivered prior to the authorization date approved by DMAS or a DMAS-contracted entity. Any CSP for home and community-based care services must be preapproved by DMAS prior to Medicaid reimbursement for waiver services.

D. Screening for the CMH waiver.

1. Clients requesting CMH waiver services will be screened and will receive services on a first-come, first-served basis based on the availability of services in the community to support the client.

2. To be eligible for CMH waiver services, the client must:

a. Have been a resident of a PRTF for at least 90 days prior to applying for the CMH waiver;

b. Continue to meet the PRTF criteria described in 12VAC30-50-130;

c. Have services identified in the community to meet the client's needs;

d. Have a case manager assigned; and

e. Continue to meet Medicaid eligibility criteria.

E. Waiver approval process: authorizing and accessing services.

1. The screener is the entity responsible for assessing the client to determine if the client meets the criteria for admission to the CMH waiver.

2. If a client is a CSA client, the screener shall be the CSA representative. If the client is not a CSA client, the screener

shall be the mental health or treatment foster care case manager.

3. Once the screener has determined that a client meets the eligibility criteria for CMH waiver services and the client or family/caregiver, as appropriate, has chosen this program, the client or family/caregiver will be provided with a list of available service providers. The client or family/caregiver, as appropriate, must be given a choice of providers if there is more than one provider available that can meet the client's needs. The client or family/caregiver, as appropriate, must also be given a choice of CD or agency-directed respite and companion services, if the client is eligible for these services.

4. When all required information has been submitted to DMAS or its contractor for preauthorization, DMAS or the contractor will have 10 business days to review preauthorization requests. If the request is approved, the client will be sent written notification of enrollment in the CMH waiver and services may begin.

5. Only CMH waiver services authorized on the CSP by the screening entity according to DMAS policies may be reimbursed by DMAS.

6. All CSPs are subject to approval by DMAS.

F. Reevaluation of service need.

1. The comprehensive service plan (CSP).

a. The CSP shall be reviewed at intervals as determined by DMAS with the case manager, client, family/caregiver, service providers, consultants, and others involved in the care of the client based on relevant, current assessment data.

b. The case manager is responsible for continuous monitoring of the appropriateness of the client's services and revisions to the CSP as indicated by the changing needs of the client. The case manager must review the CSP at least every three months to determine whether service goals and objectives are being met and whether any modifications to the CSP are necessary.

c. Any modification to the amount or type of services in the CSP must be approved by the client or family/caregiver, as appropriate, and be pre-authorized by DMAS.

2. Review of level-of-care.

a. The case manager shall complete a reassessment annually, in coordination with the client, family/caregiver, service providers, consultants, and others involved in the care of the client, to ensure that the client continues to meet the PRTF criteria. The reassessment shall include the completion of the assessment instrument and any other appropriate assessment data. If warranted, the case manager shall coordinate a medical examination and a mental health assessment for the client. The CSP shall be revised as appropriate.

b. A new mental health assessment shall be required whenever the current mental health assessment is no longer reflective of the client's current condition.

3. The case manager will monitor the service providers' ISPs to ensure that all providers are working toward the identified goals of the client.

4. Case managers will be required to conduct a minimum of quarterly face-to-face visits for all CMH waiver clients.

VA.R. Doc. No. R10-2346; Filed May 4, 2010, 1:40 p.m.

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TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARD OF ACCOUNTANCY

Notice of Extension of Emergency Regulation

Title of Regulation: **18VAC5-21. Board of Accountancy Regulations (amending 18VAC5-21-30).**

Statutory Authority: §§ 54.1-4402 and 54.1-4403 of the Code of Virginia.

Effective Dates: May 14, 2009, through November 13, 2010.

Pursuant to § 2.2-4011 of the Code of Virginia, the Virginia Board of Accountancy (board) requested an extension of the above-referenced emergency regulation to complete the requirements of the Administrative Process Act. The emergency regulations were published in 25:20 VA.R. 3642-3645 June 8, 2009 (http://register.dls.virginia.gov/vol25/iss20/v25i20.pdf).

The board proposed this emergency regulation to reduce the amount of education required for licensure that must be obtained prior to taking the certified public accountant (CPA) examination through Virginia so that the requirement was no more restrictive than that of most other states. The proposed emergency regulation also defined "accounting concentration or equivalent," which is a requirement for licensure and for taking the CPA examination through Virginia.

The emergency regulation became effective May 14, 2009, and contained all education requirements for taking the CPA examination through Virginia. Those requirements have been incorporated into the accounting programs of Virginia's colleges and universities and into the plans of students and others for taking the CPA examination through Virginia. The board intended for the provisions of the emergency regulation to become permanent as part of a separate fast track regulatory action containing comprehensive changes to the board's regulations in response to revisions to the accountancy statutes that became effective July 1, 2007.

The proposed fast-track regulations, however, will not become effective before the scheduled expiration of the emergency regulation on May 13, 2010. Allowing the emergency regulation to expire would impose an unconscionable burden on students and others who have, in good faith, adopted plans based on the emergency regulation. Expiration of the emergency regulation also would significantly reduce the board's revenues, as individuals would begin taking the CPA examination through states that already have the same requirements as those in the emergency regulations. Therefore, the board requested a six-month extension to November 13, 2010.

The Governor approved the board's request to extend the expiration date of the emergency regulation for six months as provided in § 2.2-4011 D of the Code of Virginia. Therefore, the regulations will continue in effect through November 13, 2010.

Agency Contact: Wade A. Jewell, Executive Director, Board of Accountancy, 9960 Mayland Drive, Perimeter Center, Suite 402, Richmond, VA 23233, telephone (804) 367-8540, FAX (804) 527-4409, or email wade.jewell@boa.virginia.gov.

VA.R. Doc. No. R09-1099; Filed May 12, 2010, 2:34 p.m.

DEPARTMENT OF CONSERVATION AND RECREATION

Proposed Consent Special Order for Harrell Contracting, Inc.

Purpose of notice: To seek public comment on the terms of a proposed Consent Special Order (order) issued to Harrell Contracting, Inc.

Public comment period: May 24, 2010, through June 23, 2010.

Summary of proposal: The proposed order describes a settlement between the Virginia Soil and Water Conservation Board and Harrell Contracting, Inc. to resolve alleged past violations of the Virginia Stormwater Water Management Act and the Virginia Stormwater Management Program (VSMP) Permit Regulations at the Quality Culvert construction project in Greensville County, Virginia. The proposed order requires payment of a $20,550 civil charge.

How to comment: The Virginia Department of Conservation and Recreation accepts written comments from the public by mail, email, or facsimile. All comments must include the name, address, and telephone number of the person commenting. Comments must be received during the comment period. A copy of the proposed order is available on request from the person identified directly below as the contact.

Contact for public documents and additional information: David Kearney, Virginia Department of Conservation and Recreation, 203 Governor Street, Suite 206, Richmond, VA 23219, telephone (804) 225-2558, FAX (804) 786-1798, or email david.kearney@dcr.virginia.gov.

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

DEPARTMENT OF ENVIRONMENTAL QUALITY

Modification of Appomattox River Total Maximum Daily Load

Notice is hereby given that the Virginia Department of Environmental Quality (DEQ) seeks comment on proposed modifications to the bacteria total maximum daily load (TMDL) developed for the Appomattox River and tributaries located in Appomattox, Buckingham, Cumberland, Prince Edward, Amelia, Nottoway, Powhatan, Chesterfield, Dinwiddie, and Prince George Counties and the Cities of Petersburg, Colonial Heights, and Hopewell, Virginia. A TMDL of E. coli was developed to address the bacterial impairments in the Appomattox River Basin. This TMDL was approved by the federal Environmental Protection Agency on August 30, 2004, and can be found at the following website: http://www.deq.virginia.gov/tmdl/apptmdls/jamesrvr/app.pdf. DEQ seeks written comments from interested persons on the modification of this TMDL.

The U.S. Army Garrison and Fort Lee (VPDES Permit #0059161) is an industrial minor facility that discharges to the Appomattox River (segment 3). The facility was assigned a waste load allocation (WLA) of 8.73E+11 cfu/year in the TMDL based on the design flow of 0.5 million gallons per day (MGD). However, this facility is a potable water treatment plant (not a sewage treatment plant); therefore, the discharge from this facility is not considered to contribute bacteria and monitoring of the effluent is not required under the permit.

The Appomattox River Water Authority (VPDES Permit #0005819) is an industrial minor facility that discharges to an unnamed tributary of Lake Chesdin (segment 2 of Appomattox River). The facility was assigned a WLA of 4.70E+12 cfu/year in the TMDL based on the design flow of 2.7 MGD. However, this facility is a potable water treatment plant (not a sewage treatment plant); therefore, the discharge from this facility is not considered to contribute bacteria and monitoring of the effluent is not required under the permit.

Therefore, DEQ proposes the following changes to the report:

- Remove the WLA assigned to U.S. Army Garrison and Fort Lee (VPDES Permit #0059161) and add the 8.73E+11 cfu/year to a future growth load for segment 3 of the Appomattox River (as stated in the report). This facility's outfall lies within segment 3.
- Remove the WLA assigned to the Appomattox River Water Authority (VPDES Permit #0005819) in segments 2 and 3 of the Appomattox River and add the 4.70E+12 cfu/year to a future growth load for the respective segments. This facility's outfall lies within segment 2. The WLA portion of this facility assigned in segment 3 was intended to be protective of the downstream impairment and will be added to the future growth load in segment 3.
- Total future growth load (moved from the WLA) in segment 2 will equal 4.70E+12 cfu/year.
- Total future growth load (moved from the WLA) in segment 3 will equal 5.57E+12 cfu/year.

For the bacterial TMDL, the proposed WLA changes will neither cause nor contribute to the nonattainment of the Appomattox River basin (0% increase).

The public comment period for this modification will end on June 23, 2010. Please include the name, address, and telephone number of the person submitting comments or questions and send to Margaret Smigo, Department of

Environmental Quality, Piedmont Regional Office, 4969-A Cox Road, Glen Allen, VA 23060, telephone (804) 527-5124, or email margaret.smigo@deq.virginia.gov.

Draft Permit and Total Maximum Daily Load Modification in Augusta County

Purpose of notice: To seek public comment on a draft permit from the Virginia Department of Environmental Quality (DEQ) and associated modifications of a total maximum daily load (TMDL) that will allow the release of industrial wastewater from potable water treatment plant into a water body in Augusta County, Virginia.

First public notice issue date: April 30, 2010.

Public comment period: 30 days following first public notice issue date.

Permit name and number: Virginia Pollutant Discharge Elimination System Permit - Wastewater (Permit No. VA0084212) issued by DEQ, under the authority of the State Water Control Board.

Name and address of applicant: Augusta County Service Authority, 18 Government Center Lane, P.O. Box 859, Verona, VA 24482.

Name and address of facility: Churchville Water Treatment Plant, 356 Buffalo Gap Highway, Churchville, VA 24421.

Project description: The Augusta County Service Authority has applied for reissuance of the referenced permit. The applicant proposes to release treated industrial wastewater from a potable water treatment plant at a rate of 0.14 million gallons per day (MGD) into Whiskey Creek in Augusta County in the Middle River watershed. A watershed is the land area drained by a river and its incoming streams. The permit will limit the following pollutants to amounts that protect water quality: solids, chlorine, bacteria, chloride, and pH.

Modification of Middle River TMDL: A TMDL has been developed for bacteria to address recreational use impairment in the Middle River. This TMDL was approved by the federal Environmental Protection Agency on August 10, 2004, and can be found at the following website: http://www.deq.virginia.gov/tmdl/apptmdls/shenrvr/middle.pdf. DEQ proposes to modify the wasteload allocation tables in this TMDL to accommodate the increased discharge from this facility. The revised WLA tables would accommodate this discharge at a permitted design flow of 0.14 MGD and at permitted E. coli concentration of 126 cfu/100ml. This equates to an annual bacteria WLA of 2.44 x 1011 cfu/100ml for this facility.

How to comment and/or request a public hearing: DEQ accepts comments and requests for public hearing by email, fax, or postal mail. All comments and requests must be in writing and be received by DEQ during the comment period. Submittals must include the names, mailing addresses, and telephone numbers of the commentator/requestor and of all persons represented by the commentator/requestor. A request for public hearing must also include: (i) the reason why a public hearing is requested; (ii) a brief, informal statement regarding the nature and extent of the interest of the requestor or of those represented by the requestor, including how and to what extent such interest would be directly and adversely affected by the permit; and (iii) specific references, where possible, to terms and conditions of the permit with suggested revisions. DEQ may hold a public hearing, including another comment period, if public response is significant and there are substantial, disputed issues relevant to the permit.

Contact for public comments, document requests, and additional information: Tara Sieber, Department of Environmental Quality, Valley Regional Office, 4411 Early Road, P.O. Box 3000, Harrisonburg, VA 22801, telephone (540) 574-7870, FAX (540) 574-7878, or email tara.sieber@deq.virginia.gov.

Modification of Total Maximum Daily Load for Mattox Creek

Notice is hereby given that the Virginia Department of Environmental Quality (DEQ) seeks comment on the proposed modifications to the bacteria total maximum daily load (TMDL) developed for Mattox Creek in King George and Westmoreland Counties.

The Mattox Creek TMDL was developed to address bacterial impairments in portions of the free-flowing and tidal segments of Mattox Creek. The TMDL was approved by the federal Environmental Protection Agency (EPA) on August 2, 2006, and can be found at the following website: http://www.deq.virginia.gov/tmdl/apptmdls/potrvr/mattox.pdf.

DEQ seeks written comments from interested persons on the modification of this TMDL. In the Mattox Creek Bacteria TMDL approved by the EPA and the Virginia State Water Control Board in 2006, these changes are necessary for the following permitted dischargers:

- The Washington District Elementary School (VA0082058) is a VPDES minor municipal plant in Montross, Virginia. The facility, which discharges to the free-flowing segment, was incorrectly assigned a waste load allocation (WLA) of 2.2E+06 cfu/year, based on the available discharge monitoring report (DMR) records at the time of issuance. The TMDL included a WLA expansion factor for permitted facilities. DEQ proposes to revise the TMDL by increasing the bacteria WLA to 1.06E+10 cfu/year to accommodate this facility at a maximum design flow of 0.006 million gallons per day (MGD) at an E. coli concentration of 126 N/100mL. This will also change

the WLA expansion factor from 1.1E+07 to 3.1E+10 (based on a 300% growth in the WLA for the free-flowing recreation impairment). The change to the WLA is not the result of any permit change; rather, the original TMDL contained incorrect values for the design flow and WLA for this facility.

- The Washington District Elementary School (VA0082058) was not originally assigned WLAs for the downstream tidal impairment in the TMDL report as it should have been. DEQ proposes to revise the TMDL by assigning a bacteria WLA of 2.93E+09 cfu/year to accommodate this facility at a maximum design flow of 0.006 MGD and assign a WLA expansion factor of 1.47E+10 cfu/year at an Enterococci concentration of 35 N/100mL (based on a 500% growth in the WLA for the tidal recreation impairment). The change to the WLA is not the result of any permit change; rather, the original TMDL did not contain a necessary WLA for this facility for the impaired downstream tidal segment.

- The Outdoor World Harborview facility (VA0089087) is a VPDES minor municipal plant in Oak Grove, Virginia. The facility, which discharges to the tidal segment, was incorrectly assigned a WLA of 1.7E+05 cfu/year, based on the long-term average flow of the facility. The TMDL included a WLA expansion factor for permitted facilities. DEQ proposes to revise the TMDL by assigning a bacteria WLA of 9.78E+09 cfu/year to accommodate this facility at a maximum design flow of 0.02 MGD. This change will also change the WLA expansion factor from 8.5E+05 to 4.89E+10 cfu/year at an Enterococci concentration of 35 N/100mL (for the tidal recreation impairment). The change to the WLA is not the result of any permit change; rather, the original TMDL contained incorrect values for the design flow and WLA for this facility.

- The Outdoor World Harborview facility (VA0089087) was also assigned a WLA of 3.0E+05 cfu/year based on the long-term average flow of the facility. The TMDL included a WLA expansion factor for permitted facilities. DEQ proposes to revise the TMDL by assigning the bacteria WLA of 5.53E+09 cfu/year to accommodate this facility at a maximum design flow of 0.02 MGD. This change would also increase the WLA expansion factor from 1.5E+06 to 2.77E+10 cfu/year at a fecal coliform concentration of 20 N/100mL – per the facility's limit as recommended by the Virginia Department of Health for UV disinfection (for the shellfish impairment). The change to the WLA is not the result of any permit change; rather, the original TMDL contained incorrect values for the fecal coliform limit, design flow, and WLA for this facility. This facility has not yet been constructed.

The proposed changes above will neither cause nor contribute to the nonattainment of Mattox Creek, as documented in the EPA approved TMDL report.

The public comment period for this modification will end on June 23, 2010. Written comments should include the name, address, and telephone number of the person submitting the comments and should be sent to Margaret Smigo, Piedmont Regional Office, Department of Environmental Quality, 4949-A Cox Road, Glen Allen, VA 23060, telephone (804)527-5124, or email margaret.smigo@deq.virginia.gov.

Total Maximum Daily Load for Nebletts Mill Run in Sussex County and Hatcher Run in Dinwiddie County

Public meeting: Wednesday, June 16, 2010, at 2:30 p.m. at the Rowanty Technical Center located at 20000 Rowanty Road, Carson, VA 23830.

Purpose of notice: The Virginia Department of Environmental Quality (DEQ) and the Department of Conservation and Recreation have been developing a total maximum daily load (TMDL) report, which is a water quality study to quantify the bacteria pollution sources in an unnamed tributary (UT) to Nebletts Mill Run in Sussex County and Hatcher Run in Dinwiddie County. This notice announces the final public meeting on June 16, 2010, and a public comment opportunity that begins on June 17, 2010.

Meeting description: A summary presentation will be given of the draft TMDL report regarding the water quality impairments of the streams mentioned above that fail the recreational use due to bacterial violations. The meeting will serve as an opportunity for the public to offer input regarding the impaired watersheds and to ask questions regarding the water quality study and report development. The presentation will include loadings and suggested reductions of bacteria in order to meet water quality standards for recreational use.

Description of study: Virginia agencies have been working to identify and quantify sources of the bacterial contamination for Hatcher Run and an UT to Nebletts Mill Run. The former impairment spans approximately 4 miles and the latter approximately 2 miles. These waterways are impaired for failure to meet the recreational designated use due to exceedances of the bacteria water quality standard.

Waterbody	Location	Impaired Length (mi)	Impairment
Hatcher Run (VAP_K23R-05-BAC)	Dinwiddie County (from headwaters to the pond below Rt. 627)	4.36	Recreational Use
Unnamed Tributary to Nebletts Mill Run (VAP_K23R-03-BAC)	Sussex County	1.73	
Total Impaired Length		6.09	

The study reports on the current status of the streams via sampling performed by DEQ and the possible sources of bacterial contamination. The study recommends TMDLs for the above impairments. To restore water quality, bacteria levels have to be reduced to the TMDL amount.

How to comment: DEQ accepts written comments by email, fax, or postal mail. Written comments should include the name, address, and telephone number of the person commenting and be received by DEQ during the comment period, which begins on June 17, 2010, and expires July 19, 2010.

Contact for additional information: Margaret Smigo, TMDL Coordinator, Department of Environmental Quality, Piedmont Regional Office, 4949A Cox Road, Glen Allen, VA, 23060, telephone (804) 527-5124, Fax (804)-527-5106, or email margaret.smigo@deq.virginia.gov.

STATE BOARD OF HEALTH AND DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Proposed Notice of Request for Certificate of Public Need Applications for Development of Additional Nursing Home Beds Planning Target Year 2013

Legal Notice of Request for Certificate of Public Need Applications.

Pursuant to the authority vested in the State Board of Health (board) and the Department of Medical Assistance Services (DMAS) by § 32.1-102.3:2 of the Code of Virginia, notice is hereby given of the proposed issuance of a request for applications (RFA). This RFA would be a request for certificate of public need (COPN) applications for projects that would result in an increase in the number of beds in which nursing home services are provided in the Commonwealth of Virginia. The RFA process is outlined in 12VAC5-220-335 of the Virginia Medical Care Facilities Certificate of Public Need Rules and Regulations.

Eligible Planning District and Total Nursing Home Beds Available for Authorization.

In the review cycles that would be established by this RFA upon issuance of the final notice, the Commissioner of Health will consider requests for COPNs that propose an increase in nursing home beds in the planning districts (PD) identified below and that propose an increase in beds no greater than the number of available beds shown below for that planning district. COPN requests that propose an increase in nursing home beds in any other planning district not identified below or propose an increase in beds greater than the number of available beds shown below for the eligible planning district will not be accepted for review.

Planning District 9, also known as the Rappahannock-Rapidan Planning District, consisting of the counties of Culpeper, Fauquier, Madison, Orange, and Rappahannock.
Total nursing home beds available for authorization: 60.

Planning District 10, also known as the Thomas Jefferson Planning District, consisting of the counties of Albemarle, Fluvanna, Greene, Louisa, and Nelson and the city of Charlottesville.
Total nursing home beds available for authorization: 60.

Planning District 18, also known as the Middle Peninsula Planning District, consisting of the counties of Essex, Gloucester, King and Queen, King William, Matthews, and Middlesex.
Total nursing home beds available for authorization: 30.

Evaluation of Need for Additional Nursing Home Beds.

The "Nursing Facilities" component of the Virginia State Medical Facilities Plan contains a nursing home bed need forecasting method (12VAC5-230-610). This method has been employed by the Virginia Department of Health to compute a forecast of needed nursing home beds in 2013 in each of Virginia's twenty-two planning districts.[1]

Consistent with 12VAC5-230-610 A, no planning district is considered to have a need for additional nursing home beds unless the average annual occupancy of all existing Medicaid-certified nursing home beds in the planning district was at least 93%, excluding the bed inventory and utilization of the Virginia Veterans Care Centers.

For purposes of this document, the annual occupancy of Medicaid-certified nursing home beds was determined from filings with Virginia Health Information made by Virginia nursing homes covering their fiscal year 2008. The average annual occupancy of one planning district was adjusted to take into account the fact that one nursing home in the planning district, although Medicaid-certified at the end of its fiscal year, had a substantial period of nonparticipation in the

Medicaid program during the nursing home's fiscal year 2008.

Also, no planning district will be considered to have a need for additional nursing home beds if there are uncompleted nursing home beds, for which Medicaid certification will be sought, that were authorized for the planning district within the three years prior to this notice of a proposed RFA. The following table displays, by planning district, the nursing home gross bed need forecast for 2013, the current licensed bed inventory plus uncompleted COPN-authorized additions of nursing home beds, and the net bed need forecast for 2013.

The table also shows the average annual occupancy rate of Medicaid-certified nursing home beds for each planning district for the 2008 reporting year and identifies the status of each planning district with respect to authorized but uncompleted nursing home beds. The final column of the table states whether the planning district qualifies for additional nursing home beds for 2013.

Nursing Home Bed Need Forecast and
Whether a Planning District Qualifies for Additional Nursing Home Beds for 2013

Planning District	Gross Bed Need Forecast For 2013	Existing Plus Authorized Beds	Projected Net Bed Need In 2013	Average Occupancy Medicaid Beds 2008	Authorized But Uncompleted Medicaid Beds	Planning District Qualifies for Additional NH Beds
1	511	641	(130)	88.4%	no	no--no need
2	426	547	(121)	76.7%	no	no--no need
3	1,378	1,405	(27)	93.1%	no	no--no need
4	828	788	40	85.7%	no	no--low occu.
5	2,046	2,301	(255)	91.0%	no	no--no need
6	1,746	1,528	218	92.4%	no	no--low occu.
7	966	972	(6)	89.2%	no	no--no need
8	5,026	4,358	668	89.6%	no	no--low occu.
9	815	746	69	93.7%	no	yes--60 beds
10	1,081	1,007	74	93.4%	no	yes--60 beds
11	1,512	1,550	(38)	92.9%	no	no--no need
12	2,036	1,929	107	91.8%	no	no--low occu.
13	935	881	54	92.9%	yes	no--low occu.
14	638	665	(27)	95.4%	yes	no--no need
15	3,927	4,049	(122)	93.0%	yes	no--no need
16*	825	785	40	92.4%	no	no--low occu.
17	332	368	(36)	79.2%	no	no--no need.
18	593	550	43	93.0%	no	yes--30 beds
19	1,099	1,075	24	91.0%	no	no--low occu.
20	4,547	4,421	126	90.2%	no	no--low occu.
21	2,056	1,875	181	92.5%	no	no--low occu.
22	377	389	(12)	89.8%	no	no--no need
Total VA	33,700	32,830	870	91.0%		

[1] For conduct of the certificate of public need program, the Virginia Department of Health continues to recognize the former Planning District 20, Southeastern Virginia, and the former Planning District 21, Peninsula, rather than Planning District 23, Hampton Roads, which combined the former PD 20 and PD 21.

Sources: Virginia State Medical Facilities Plan (12VAC5-230-610)
Virginia Employment Commission (population projections, 2007 edition)
2006 Virginia Nursing Home Patient Survey, Health Systems Agency of Northern Virginia (for age-specific nursing home use rates)
Office of Licensure and Certification, VDH (for bed inventory)

*Note to table: There are 90 authorized but uncompleted nursing home beds in PD 16 that are expected to be Medicaid-certified. However, by virtue of provisions of HB 267 of the 2006 General Assembly (Chap. 816 of the 2006 Acts of Assembly), the existence of these uncompleted beds is not to keep PD 16 from being the subject of an RFA, if PD 16 otherwise qualifies for an RFA. Therefore, PD 16 is shown above as having no uncompleted beds expected to be certified for Medicaid.

Basis for Review.

The Commissioner, in her review of COPN requests submitted pursuant to this RFA, will consider each of the eight factors enumerated in § 32.1-102.3 B of the Code of Virginia, as applicable. She will also consider applicable standards of the State Medical Facilities Plan (12VAC5-230-600 et. seq.).

Projection of Potential Fiscal Impact.

The Department of Medical Assistance Services projects total additional expenditures for medical services provided to Medicaid recipients of approximately $4.29 million ($2.14 million of Commonwealth general funds) for the fiscal year ending June 30, 2014, if all 150 beds included in this RFA are authorized and available for occupancy by July 1, 2013. This projection is based on the following principal assumptions:

Average proportion of beds filled during FY 2014	90.69%
Assumed Medicaid proportion of bed-days of service	61.24%
Average estimated payment rate per day (net of patient co-payments)	$140.69

Schedule for Review.

COPN requests filed in response to this RFA must be filed in accordance with the provisions of 12VAC5-220-355. The review schedules shown below will apply. Letters of intent and applications must be received by the Virginia Department of Health Division of COPN and by the applicable regional health planning agency, if one is then in operation, by the dates shown below in order to qualify for consideration in the specified review cycle.

Letter of intent must be received by (to be stated in the final notice).

Application must be received by (to be stated in the final notice).

Review cycle will begin on (to be stated in the final notice).

Application Fees.

The Virginia Department of Health shall collect fees for COPN applications filed in response to this RFA. No application may be deemed to be complete for review until the required application fee is paid. The fee is one percent of the proposed capital expenditure for the project, but not less than $1,000 or more than $20,000.

STATE LOTTERY DEPARTMENT

Director's Order

The following Director's Orders of the State Lottery Department were filed with the Virginia Registrar of Regulations on April 1, 2010, and April 4, 2010. The orders may be viewed at the State Lottery Department, 900 East Main Street, Richmond, VA, or at the office of the Registrar of Regulations, 910 Capitol Street, 2nd Floor, Richmond, VA.

Director's Order Number Twenty-Five (10)

Virginia's Instant Game Lottery 1177; "Quick Silver" Final Rules for Game Operation (effective May 4, 2010)

Director's Order Number Twenty-Six (10)

Virginia's Instant Game Lottery 1188; "$70 Million Payout Spectacular" Final Rules for Game Operation (effective May 4, 2010)

Director's Order Number Thirty-Four (10)

Virginia's Instant Game Lottery 1173; "Muscle Car Money" Final Rules for Game Operation (effective May 4, 2010)

Director's Order Number Forty-Five (10)

Virginia Lottery's "Muscle Car Money Sweepstakes" Final Rules for Game Operation (effective May 4, 2010)

VIRGINIA CODE COMMISSION

Notice to State Agencies

Mailing Address: Virginia Code Commission, 910 Capitol Street, General Assembly Building, 2nd Floor, Richmond, VA 23219.

Cumulative Table of Virginia Administrative Code Sections Adopted, Amended, or Repealed

Beginning with Volume 26, Issue 1 of the Virginia Register of Regulations dated September 14, 2009, the Cumulative Table of Virginia Administrative Code Sections Adopted, Amended, or Repealed will no longer be published in the Virginia Register of Regulations. The cumulative table may be accessed on the Virginia Register Online webpage at http://register.dls.virginia.gov/cumultab.htm.

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.

ERRATA

STATE WATER CONTOL BOARD

Title of Regulation: **9VAC25-31. Virginia Pollutant Discharge Elimination System (VPDES) Permit Regulation.**

Publication: 26:11 VA.R. 1699-1735 February 1, 2010.

Correction to Final Regulation:

Page 1723, 9VAC25-31-130 C 5 f, line 2, after "subdivision 5" strike "f (1)"

Page 1723, 9VAC25-31-130 C 5 i, change "i. Effect of certification." to "g. Effect of certification."

VA.R. Doc. R10-2203; Filed May 11, 2010