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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, and notices of public hearings on regulations.

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.

A regulatory action may be withdrawn by the promulgating agency at any time before the regulation becomes final.

FAST-TRACK RULEMAKING PROCESS

Section 2.2-4012.1 of the Code of Virginia provides an 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 18 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. **29:5 VA.R. 1075-1192 November 5, 2012**, refers to Volume 29, Issue 5, pages 1075 through 1192 of the *Virginia Register* issued on November 5, 2012.

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

Members of the Virginia Code Commission: **John S. Edwards**, Chair; **James M. LeMunyon**, Vice Chair, **Gregory D. Habeeb**; **Ryan T. McDougle**; **Pamela S. Baskerville**; **Robert L. Calhoun**; **Carlos L. Hopkins**; **E.M. Miller, Jr.**; **Thomas M. Moncure, Jr.**; **Christopher R. Nolen**; **Timothy Oksman**; **Charles S. Sharp**; **Robert L. Tavenner**.

Staff of the Virginia Register: **Jane D. Chaffin**, Registrar of Regulations; **Karen Perrine**, Assistant Registrar; **Anne Bloomsburg**, Regulations Analyst; **Rhonda Dyer**, Publications Assistant; **Terri Edwards**, Operations Staff Assistant.

PUBLICATION SCHEDULE AND DEADLINES

This schedule is available on the *Register's* Internet home page (<http://register.dls.virginia.gov>).

November 2014 through December 2015

<u>Volume: Issue</u>	<u>Material Submitted By Noon*</u>	<u>Will Be Published On</u>
31:5	October 15, 2014	November 3, 2014
31:6	October 29, 2014	November 17, 2014
31:7	November 12, 2014	December 1, 2014
31:8	November 25, 2014 (Tuesday)	December 15, 2014
31:9	December 10, 2014	December 29, 2014
31:10	December 22, 2014 (Monday)	January 12, 2015
31:11	January 7, 2015	January 26, 2015
31:12	January 21, 2015	February 9, 2015
31:13	February 4, 2015	February 23, 2015
31:14	February 18, 2015	March 9, 2015
31:15	March 4, 2015	March 23, 2015
31:16	March 18, 2015	April 6, 2015
31:17	April 1, 2015	April 20, 2015
31:18	April 15, 2015	May 4, 2015
31:19	April 29, 2015	May 18, 2015
31:20	May 13, 2015	June 1, 2015
31:21	May 27, 2015	June 15, 2015
31:22	June 10, 2015	June 29, 2015
31:23	June 24, 2015	July 13, 2015
31:24	July 8, 2015	July 27, 2015
31:25	July 22, 2015	August 10, 2015
31:26	August 5, 2015	August 24, 2015
32:1	August 19, 2015	September 7, 2015
32:2	September 2, 2015	September 21, 2015
32:3	September 16, 2015	October 5, 2015
32:4	September 30, 2015	October 19, 2015
32:5	October 14, 2015	November 2, 2015
32:6	October 28, 2015	November 16, 2015
32:7	November 11, 2015	November 30, 2015
32:8	November 24, 2015 (Tuesday)	December 14, 2015

*Filing deadlines are Wednesdays unless otherwise specified.

NOTICES OF INTENDED REGULATORY ACTION

TITLE 12. HEALTH

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the Board of Medical Assistance Services intends to consider amending **12VAC30-120, Waivered Services**. The purpose of the proposed action is to create criteria and standards for establishing an exceptional reimbursement rate for certain individuals in the intellectual disability waiver who have exceptional care needs. The board is authorized to establish a higher reimbursement rate by Item 301 III of Chapter 2 of the 2014 Acts of Assembly, Special Session I.

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

Statutory Authority: § 32.1-325 of the Code of Virginia; 42 USC § 1396.

Public Comment Deadline: December 17, 2014.

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.

VA.R. Doc. No. R15-3839; Filed October 15, 2014, 3:23 p.m.

REGULATIONS

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

Symbol Key

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

TITLE 8. EDUCATION

STATE BOARD OF EDUCATION

Final Regulation

Title of Regulation: **8VAC20-131. Regulations Establishing Standards for Accrediting Public Schools in Virginia (amending 8VAC20-131-5, 8VAC20-131-50, 8VAC20-131-60, 8VAC20-131-110, 8VAC20-131-270, 8VAC20-131-280, 8VAC20-131-360).**

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

Effective Date: December 3, 2014.

Agency Contact: Melissa Luchau, Department of Education, James Monroe Building, 101 North 14th Street, 25th Floor, Richmond, VA 23219, telephone (804) 225-2924, FAX (804) 225-2524, or email melissa.luchau@doe.virginia.gov.

Summary:

This regulatory action makes permanent certain provisions of the emergency regulations adopted pursuant to Chapter 454 of the 2012 Acts of Assembly. The amendments (i) add the career and technical education credential requirement for the Standard Diploma, (ii) add the virtual course requirement for the Standard Diploma and the Advanced Studies Diploma, (iii) eliminate the Standard Technical Diploma and the Advanced Technical Diploma, (iv) incorporate the Modified Standard Diploma into the Standard Diploma and establish credit accommodations for students with disabilities to earn a Standard Diploma, and (v) recommend the Advanced Studies Diploma for students pursuing baccalaureate study.

Summary of Public Comments and Agency's Response: A summary of comments made by the public and the agency's response may be obtained from the promulgating agency or viewed at the office of the Registrar of Regulations.

Part I

Definitions and Purpose

8VAC20-131-5. Definitions.

The following words and terms apply only to these regulations and do not supersede those definitions used for federal reporting purposes or for the calculation of costs related to the Standards of Quality (§ 22.1-253.13:1 et seq. of the Code of Virginia). When used in these regulations, these words shall have the following meanings, unless the context clearly indicates otherwise:

"Accreditation" means a process used by the Virginia Department of Education (hereinafter "department") to

evaluate the educational performance of public schools in accordance with these regulations.

"Additional test" means a test, including substitute tests approved by the Board of Education that students may use in lieu of a Standards of Learning test to obtain verified credit.

"Class period" means a segment of time in the school day that is approximately 1/6 of the instructional day.

"Combined school" means a public school that contains any combination of or all of the grade levels from kindergarten through grade 12. This definition does not include those schools defined as elementary, middle, or secondary schools.

"Credit accommodations" means adjustments to meet the standard and verified credit requirements for earning a Standard Diploma for students with disabilities.

"Elementary school" means a public school with any grades kindergarten through five.

"Eligible students" means the total number of students of school age enrolled in the school at a grade or course for which a Standards of Learning test is required unless excluded under the provisions of 8VAC20-131-30 ~~F~~ G and 8VAC20-131-280 D relative to limited English proficient (LEP) students.

"Enrollment" means the act of complying with state and local requirements relative to the registration or admission of a child for attendance in a school within a local school division. This term also means registration for courses within the student's home school or within related schools or programs.

"First time" means the student has not been enrolled in the school at any time during the current school year (for purposes of 8VAC20-131-60 with reference to students who transfer in during the school year).

"Four core areas" or "four core academic areas" means English, mathematics, science, and history and social science for purposes of testing for the Standards of Learning.

"Graduate" means a student who has earned a Board of Education recognized diploma, which includes the Advanced Studies Diploma, ~~Advanced Technical, the Standard Diploma, Standard Technical, Modified Standard, and the Special, and General Achievement diplomas~~ Diploma.

"Homebound instruction" means academic instruction provided to students who are confined at home or in a health care facility for periods that would prevent normal school attendance based upon certification of need by a licensed physician or a licensed clinical psychologist.

"Locally awarded verified credit" means a verified unit of credit awarded by a local school board in accordance with 8VAC20-131-110.

"Middle school" means a public school with any grades 6 through 8.

"Planning period" means one class period per day or the equivalent unencumbered of any teaching or supervisory duties.

"Recess" means a segment of free time exclusive of time provided for meals during the standard school day in which students are given a break from instruction.

"Reconstitution" means a process that may be used to initiate a range of accountability actions to improve pupil performance, curriculum, and instruction to address deficiencies that caused a school to be rated Accreditation Denied that may include, but not be limited to, restructuring a school's governance, instructional program, staff or student population.

"School" means a publicly funded institution where students are enrolled for all or a majority of the instructional day and:

1. Those students are reported in fall membership at the institution; and
2. At a minimum, the institution meets the preaccreditation eligibility requirements of these regulations as adopted by the Board of Education.

"Secondary school" means a public school with any grades 9 through 12.

"Standard school day" means a calendar day that averages at least five and one-half instructional hours for students in grades 1 through 12, excluding breaks for meals and recess, and a minimum of three instructional hours for students in kindergarten.

"Standard school year" means a school year of at least 180 teaching days or a total of at least 990 teaching hours per year.

"Standard unit of credit" or "standard credit" means credit awarded for a course in which the student successfully completes 140 clock hours of instruction and the requirements of the course. Local school boards may develop alternatives to the requirement for 140 clock hours of instruction as provided for in 8VAC20-131-110.

"Standards of Learning (SOL) tests" or "SOL tests" means those criterion referenced assessments approved by the Board of Education for use in the Virginia assessment program that measure attainment of knowledge and skills required by the Standards of Learning.

"Student" means a person of school age as defined by § 22.1-1 of the Code of Virginia, a child with disabilities as defined in § 22.1-213 of the Code of Virginia, and a person with limited English proficiency in accordance with § 22.1-5 of the Code of Virginia.

"Student periods" means the number of students a teacher instructs per class period multiplied by the number of class periods taught.

"Verified unit of credit" or "verified credit" means credit awarded for a course in which a student earns a standard unit of credit and achieves a passing score on a corresponding end-of-course SOL test or an additional test approved by the Board of Education as part of the Virginia assessment program.

"Virginia assessment program" means a system used to evaluate student achievement that includes Standards of Learning tests and additional tests that may be approved from time to time by the Board of Education.

8VAC20-131-50. Requirements for graduation.

A. The requirements for a student to earn a diploma and graduate from a Virginia high school shall be those in effect when that student enters the ninth grade for the first time. Students shall be awarded a diploma upon graduation from a Virginia high school.

The Advanced Studies Diploma shall be the recommended diploma for students pursuing baccalaureate study. Both the Standard Diploma and the Advanced Studies Diploma shall prepare students for postsecondary education and the career readiness required by the Commonwealth's economy.

When students below the ninth grade successfully complete courses offered for credit in grades 9 through 12, credit shall be counted toward meeting the standard units required for graduation provided the courses are equivalent in content and academic rigor as those courses offered at the secondary level. To earn a verified unit of credit for these courses, students must meet the requirements of 8VAC20-131-110.

The following requirements shall be the only requirements for a diploma, unless a local school board has prescribed additional requirements that have been approved by the Board of Education. All additional requirements prescribed by local school boards that have been approved by the Board of Education remain in effect until such time as the local school board submits a request to the board to amend or discontinue them.

B. Requirements for a Standard Diploma.

1. Beginning with the ninth-grade class of ~~2011-2012~~ 2013-2014 and beyond, students shall earn the required standard and verified units of credit described in subdivision 2 of this subsection.

2. Credits required for graduation with a Standard Diploma.

Discipline Area	Standard Units of Credit Required	Verified Credits Required
English	4	2
Mathematics ¹	3	1

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Laboratory Science ^{2,6}	3	1
History and Social Sciences ^{3,6}	3	1
Health and Physical Education	2	
Foreign Language, Fine Arts or Career and Technical Education ⁷	2	
Economics and Personal Finance	1	
Electives ⁴	4	
Student Selected Test ⁵		1
<u>Career and Technical Education Credential</u> ⁸		
Total ⁹	22	6

¹Courses completed to satisfy this requirement shall include at least two different course selections from among: Algebra I, Geometry, Algebra, Functions, and Data Analysis, Algebra II, or other mathematics courses above the level of Algebra II. The board shall approve courses to satisfy this requirement.

²Courses completed to satisfy this requirement shall include course selections from at least two different science disciplines: earth sciences, biology, chemistry, or physics, or completion of the sequence of science courses required for the International Baccalaureate Diploma. The board shall approve courses to satisfy this requirement.

³Courses completed to satisfy this requirement shall include U.S. and Virginia History, U.S. and Virginia Government, and one course in either world history or geography or both. The board shall approve courses to satisfy this requirement.

⁴Courses to satisfy this requirement shall include at least two sequential electives as required by the Standards of Quality.

⁵A student may utilize additional tests for earning verified credit in computer science, technology, career and technical education, economics or other areas as prescribed by the board in 8VAC20-131-110.

⁶Students who complete a career and technical education program sequence and pass an examination or occupational competency assessment in a career and technical education field that confers certification or an occupational competency credential from a recognized industry, or trade or professional association, or acquires a professional license in a career and technical education field from the Commonwealth of Virginia may substitute the certification, competency credential, or license for (i) the student-selected verified credit and (ii) either a science or history and social science verified

credit when the certification, license, or credential confers more than one verified credit. The examination or occupational competency assessment must be approved by the Board of Education as an additional test to verify student achievement.

⁷Pursuant to § 22.1-253.13:4 of the Code of Virginia, credits earned for this requirement shall include one credit in fine or performing arts or career and technical education.

⁸Students shall earn a career and technical education credential approved by the Board of Education that could include, but not be limited to, the successful completion of an industry certification, a state licensure examination, a national occupational competency assessment, or the Virginia workplace readiness assessment.

⁹Students shall successfully complete one virtual course, which may be a noncredit-bearing course or a required or elective credit-bearing course that is offered online.

3. The Board of Education shall establish, through guidelines, credit accommodations to the standard and verified credit requirements for a Standard Diploma. Such credit accommodations for students with disabilities may include:

- a. Approval of alternative courses to meet the standard credit requirements;
- b. Modifications to the requirements for local school divisions to award locally awarded verified credits;
- c. Approval of additional tests to earn a verified credit;
- d. Adjusted cut scores required to earn verified credit; and
- e. Allowance of work-based learning experiences.

The student's Individual Education Program (IEP) or 504 Plan would specify any credit accommodations that would be applicable for the student.

Students completing the requirements for the Standard Diploma may be eligible to receive an honor deemed appropriate by the local school board as described in subsection ~~K~~ H of this section.

C. Requirements for a Standard Technical Diploma.

~~1. Beginning with the ninth grade class of 2012-2013 and beyond, students shall earn the required standard and verified units of credit described in subdivision 2 of this subsection.~~

~~2. Credits required for graduation with a Standard Technical Diploma.~~

Discipline Area	Standard Units of Credit Required	Verified Credits Required
English	4	2
Mathematics [†]	3	1
Laboratory Science ^{2,5}	3	1

History and Social Sciences ^{3,5}	3	1
Health and Physical Education	2	
Fine Arts or Foreign Language	1	
Economics and Personal Finance	1	
Career and Technical Education ⁴	4	
Electives	1	
Student Selected ⁶		1
Total	22	6

¹Courses completed to satisfy this requirement shall include at least three different course selections from among: Algebra I, Geometry, Algebra Functions and Data Analysis, or Algebra II or other mathematics courses above the level of Algebra II. The board shall approve courses to satisfy this requirement.

²Courses completed to satisfy this requirement shall include course selections from at least three different science disciplines from among: earth sciences, biology, chemistry, or physics, or completion of the sequence of science courses required for the International Baccalaureate Diploma. The board shall approve courses to satisfy this requirement.

³Courses completed to satisfy this requirement shall include U.S. and Virginia History, U.S. and Virginia Government, and one course in either world history or geography or both. The board shall approve courses to satisfy this requirement.

⁴Courses completed to satisfy this requirement must include a career concentration as approved by the board. If a career concentration includes a specific assessment approved by the board and the student is eligible to take the assessment, then the student must take this assessment.

⁵Students who complete a career and technical education program sequence and pass an examination or occupational competency assessment in a career and technical education field that confers certification or an occupational competency credential from a recognized industry or trade or professional association or acquires a professional license in a career and technical education field from the Commonwealth of Virginia may substitute the certification competency credential or license for (i) the student selected verified credit and (ii) either a science or history and social science verified credit when the certification license or credential confers more than one verified credit. The examination or occupational competency assessment must be approved by the board as an additional test to verify student achievement.

⁶A student may utilize additional tests for earning verified credit in computer science, technology, career and technical education, economics or other areas as prescribed by the board in 8VAC20-131-110.

Students completing the requirements for the Standard Technical Diploma may be eligible to receive an honor deemed appropriate by the local school board as described in subsection K of this section.

D. C. Requirements for an Advanced Studies Diploma. Any student who meets the requirements for both the Advanced Studies and the Advanced Technical diploma may choose between these two diplomas.)

1. Beginning with the ninth-grade class of ~~2011-2012~~ 2013-2014 and beyond, students shall earn the required standard and verified units of credit described in subdivision 2 of this subsection.

2. Credits required for graduation with an Advanced Studies Diploma.

Discipline Area	Standard Units of Credit Required	Verified Credits Required
English	4	2
Mathematics ¹	4	2
Laboratory Science ²	4	2
History and Social Sciences ³	4	2
Foreign Language ⁴	3	
Health and Physical Education	2	
Fine Arts or Career and Technical Education	1	
Economics and Personal Finance	1	
Electives	3	
Student Selected Test ⁵		1
Total⁶	26	9

¹Courses completed to satisfy this requirement shall include at least three different course selections from among: Algebra I, Geometry, Algebra II, or other mathematics courses above the level of Algebra II. The board shall approve courses to satisfy this requirement.

²Courses completed to satisfy this requirement shall include course selections from at least three different science disciplines from among: earth sciences, biology, chemistry, or physics or completion of the sequence of science courses required for the International Baccalaureate Diploma. The board shall approve additional courses

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to satisfy this requirement.

³Courses completed to satisfy this requirement shall include U.S. and Virginia History, U.S. and Virginia Government, and two courses in either world history or geography or both. The board shall approve additional courses to satisfy this requirement.

⁴Courses completed to satisfy this requirement shall include three years of one language or two years of two languages.

⁵A student may utilize additional tests for earning verified credit in computer science, technology, career or technical education, economics or other areas as prescribed by the board in 8VAC20-131-110.

⁶Students shall successfully complete one virtual course, which may be a noncredit-bearing course, or may be a course required to earn this diploma that is offered online.

Students completing the requirements for the Advanced Studies Diploma may be eligible to receive an honor deemed appropriate by the local school board as described in subsection ~~K~~ H of this section.

~~E. Requirements for an Advanced Technical Diploma. Any student who meets the requirements for both the Advanced Studies and the Advanced Technical diploma may choose between these two diplomas.~~

~~1. Beginning with the ninth grade class of 2012-2013 and beyond, students shall earn the required standard and verified units of credit described in subdivision 2 of this subsection.~~

~~2. Credits required for graduation with an Advanced Technical Diploma.~~

Discipline Area	Standard Units of Credit Required	Verified Credits Required
English	4	2
Mathematics ¹	4	2
Laboratory Science ²	4	2
History and Social Sciences ³	4	2
Foreign Language ⁴	3	
Health and Physical Education	2	
Economics and Personal Finance	1	
Fine Arts or Career and Technical Education	1	

Career and Technical Education ⁵	3	
Student Selected Test ⁶		1
Total	26	9

¹Courses completed to satisfy this requirement shall include at least three different course selections from among: Algebra I, Geometry, Algebra II, or other mathematics courses above the level of Algebra II. The board shall approve courses to satisfy this requirement.

²Courses completed to satisfy this requirement shall include course selections from at least three different science disciplines from among: earth sciences, biology, chemistry, or physics or completion of the sequence of science courses required for the International Baccalaureate Diploma. The board shall approve courses to satisfy this requirement.

³Courses completed to satisfy this requirement shall include U.S. and Virginia History, U.S. and Virginia Government, and two courses in either world history or geography or both. The board shall approve courses to satisfy this requirement.

⁴Courses completed to satisfy this requirement shall include three years of one language or two years of two languages.

⁵Courses completed to satisfy this requirement must include a career concentration as approved by the board. If a career concentration includes a specific assessment approved by the board, and the student is eligible to take the assessment, then the student must take this assessment.

⁶A student may utilize additional tests for earning verified credit in computer science, technology, career or technical education, economics, or other areas as prescribed by the board in 8VAC20-131-110.

~~Students completing the requirements for the Advanced Technical Diploma may be eligible to receive an honor deemed appropriate by the local school board as described in subsection K of this section.~~

~~F. Requirements for the Modified Standard Diploma.~~

~~1. Every student shall be expected to pursue a Standard Diploma, Standard Technical Diploma, Advanced Studies Diploma, or Advanced Technical Diploma. The Modified Standard Diploma program is intended for certain students at the secondary level who have a disability and are unlikely to meet the credit requirements for a Standard Diploma. Eligibility and participation in the Modified Standard Diploma program shall be determined by the student's Individualized Education Program (IEP) team including the student, where appropriate, at any point after the student's eighth grade year.~~

~~2. The school must secure the informed written consent of the parent/guardian and the student to choose this diploma program after review of the student's academic history and the full disclosure of the student's options.~~

~~3. The student who has chosen to pursue a Modified Standard Diploma shall also be allowed to pursue the Standard Diploma, Standard Technical Diploma, Advanced Studies Diploma, or Advanced Technical Diploma at any time throughout that student's high school~~

career, and the student must not be excluded from courses and tests required to earn these diplomas.

~~4. Students pursuing the Modified Standard Diploma shall pass literacy and numeracy competency assessments prescribed by the board.~~

~~5. Credits required for graduation with a Modified Standard Diploma.~~

Discipline Area	Standard Units of Credit Required
English	4
Mathematics ¹	3
Science ²	2
History and Social Sciences ³	2
Health and Physical Education	2
Fine Arts or Career and Technical Education	1
Electives ⁴	6
Total	20

¹Courses completed to satisfy this requirement shall include content from among applications of algebra, geometry, personal finance, and probability and statistics in courses that have been approved by the board.

²Courses completed shall include content from at least two of the following: applications of earth science, biology, chemistry, or physics in courses approved by the board.

³Courses completed to satisfy this requirement shall include one unit of credit in U.S. and Virginia History and one unit of credit in U.S. and Virginia Government in courses approved by the board.

⁴Courses to satisfy this requirement shall include at least two sequential electives in the same manner required for the Standard Diploma.

~~6. The student must meet any additional criteria established by the Board of Education.~~

~~G. D.~~ In accordance with the requirements of the Standards of Quality, students with disabilities who complete the requirements of their Individualized Education Program (IEP) and do not meet the requirements for other diplomas shall be awarded Special Diplomas.

~~H. E.~~ In accordance with the requirements of the Standards of Quality, students who complete prescribed programs of studies defined by the local school board but do not qualify for a Standard Diploma, Standard Technical, an Advanced Studies Diploma, Advanced Technical, Modified Standard, or a Special, or General Achievement diplomas Diploma shall be awarded Certificates of Program Completion. The requirements for Certificates of Program Completion are developed by local school boards in accordance with the Standards of Quality. Students receiving a general achievement diploma shall comply with 8VAC20-680, Regulations Governing the General Achievement Diploma.

~~I. F.~~ In accordance with the provisions of the compulsory attendance law and 8VAC20-360, Regulations Governing General Educational Development Certificates, students who do not qualify for diplomas may earn a high school equivalency credential.

~~J. G.~~ At a student's request, the local school board shall communicate or otherwise make known to institutions of higher education, potential employers, or other applicable third parties, in a manner that the local school board deems appropriate, that a student has attained the state's academic expectations by earning a Virginia diploma and that the value of such a diploma is not affected in any way by the accreditation status of the student's school.

~~K. H.~~ Awards for exemplary student performance. Students who demonstrate academic excellence and/or outstanding achievement may be eligible for one or more of the following awards:

1. Students who complete the requirements for an Advanced Studies Diploma or ~~Advanced Technical Diploma~~ with an average grade of "B" or better, and successfully complete college-level coursework that will earn the student at least nine transferable college credits in Advanced Placement (AP), International Baccalaureate (IB), Cambridge, or dual enrollment courses shall receive the Governor's Seal on the diploma.

2. Students who complete the requirements for a Standard Diploma, ~~Standard Technical Diploma, or an~~ Advanced Studies Diploma or ~~Advanced Technical Diploma~~ with an average grade of "A" shall receive a Board of Education Seal on the diploma.

3. The Board of Education's Career and Technical Education Seal will be awarded to students who earn a Standard Diploma, ~~Standard Technical Diploma, or an~~ Advanced Studies Diploma or ~~Advanced Technical Diploma~~ and complete a prescribed sequence of courses in a career and technical education concentration or specialization that they choose and maintain a "B" or better average in those courses; or (i) pass an examination or an occupational competency assessment in a career and technical education concentration or specialization that confers certification or occupational competency credential from a recognized industry, trade or professional association or (ii) acquire a professional license in that career and technical education field from the Commonwealth of Virginia. The Board of Education shall approve all professional licenses and examinations used to satisfy these requirements.

4. The Board of Education's Seal of Advanced Mathematics and Technology will be awarded to students who earn either a Standard Diploma, ~~Standard Technical Diploma, or an~~ Advanced Studies Diploma or ~~Advanced Technical Diploma~~ and (i) satisfy all of the mathematics requirements for the Advanced Studies Diploma or ~~Advanced Technical Diploma~~ (four units of credit

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including Algebra II; two verified units of credit) with a "B" average or better; and (ii) either (a) pass an examination in a career and technical education field that confers certification from a recognized industry, or trade or professional association; (b) acquire a professional license in a career and technical education field from the Commonwealth of Virginia; or (c) pass an examination approved by the board that confers college-level credit in a technology or computer science area. The Board of Education shall approve all professional licenses and examinations used to satisfy these requirements.

5. The Board of Education's Seal for Excellence in Civics Education will be awarded to students who earn either a ~~Modified Standard Diploma, Standard Diploma, Standard Technical Diploma, or an~~ Advanced Studies Diploma, ~~or Advanced Technical Diploma~~ and (i) complete Virginia and United States History and Virginia and United States Government courses with a grade of "B" or higher; (ii) have good attendance and no disciplinary infractions as determined by local school board policies; and (iii) complete 50 hours of voluntary participation in community service or extracurricular activities. Activities that would satisfy the requirements of clause (iii) of this subdivision include: (a) volunteering for a charitable or religious organization that provides services to the poor, sick, or less fortunate; (b) participating in Boy Scouts, Girl Scouts, or similar youth organizations; (c) participating in JROTC; (d) participating in political campaigns or government internships, or Boys State, Girls State, or Model General Assembly; or (e) participating in school-sponsored extracurricular activities that have a civics focus. Any student who enlists in the United States military prior to graduation will be deemed to have met this community service requirement.

6. Students may receive other seals or awards for exceptional academic, career and technical, citizenship, or other exemplary performance in accordance with criteria defined by the local school board.

~~L. I.~~ I. Students completing graduation requirements in a summer school program shall be eligible for a diploma. The last school attended by the student during the regular session shall award the diploma unless otherwise agreed upon by the principals of the two schools.

~~M. J.~~ J. Students who complete Advanced Placement courses, college-level courses, or courses required for an International Baccalaureate Diploma shall be deemed to have completed the requirements for graduation under these standards provided they have earned the standard units of credit and earned verified units of credit in accordance with the requirements ~~of~~ for the Standard Diploma and the Advanced Studies Diploma, as specified in subsections B and C of this section.

~~N. K.~~ K. Students shall be counseled annually regarding the opportunities for using additional tests for earning verified

credits as provided in accordance with the provisions of 8VAC20-131-110, and the consequences of failing to fulfill the obligations to complete the requirements for verified units of credit.

8VAC20-131-60. Transfer students.

A. The provisions of this section pertain generally to students who transfer into Virginia high schools. Students transferring in grades K-8 from Virginia public schools or nonpublic schools accredited by one of the approved accrediting constituent members of the Virginia Council for Private Education shall be given recognition for all grade-level work completed. The academic record of students transferring from all other schools shall be evaluated to determine appropriate grade placement in accordance with policies adopted by the local school board. The State Testing Identifier (STI) for students who transfer into a Virginia public school from another Virginia public school shall be retained by the receiving school.

B. For the purposes of this section, the term "beginning" means within the first 20 hours of instruction per course. The term "during" means after the first 20 hours of instruction per course.

C. Standard or verified units of credit earned by a student in a Virginia public school shall be transferable without limitation regardless of the accreditation status of the Virginia public school in which the credits were earned. Virginia public schools shall accept standard and verified units of credit from other Virginia public schools, Virginia's virtual learning program, Virtual Virginia, and state-operated programs. Standard units of credit also shall be accepted for courses satisfactorily completed in accredited colleges and universities when prior written approval of the principal has been granted or the student has been given credit by the previous school attended.

D. A secondary school shall accept credits toward graduation received from Virginia nonpublic schools accredited by one of the approved accrediting constituent members of the Virginia Council for Private Education (VCPE). The Board of Education will maintain contact with the VCPE and may periodically review its accrediting procedures and policies as part of its policies under this section.

Nothing in these standards shall prohibit a public school from accepting standard units of credit toward graduation awarded to students who transfer from all other schools when the courses for which the student receives credit generally match the description of or can be substituted for courses for which the receiving school gives standard credit, and the school from which the child transfers certifies that the courses for which credit is given meet the requirements of 8VAC20-131-110 A.

Students transferring into a Virginia public school shall be required to meet the requirements prescribed in 8VAC20-131-50 to receive a Standard, ~~Standard Technical,~~ Diploma or

an Advanced Studies Diploma, Advanced Technical, or Modified Standard Diploma, except as provided by subsection G of this section. To receive a Special Diploma or Certificate of Program Completion, a student must meet the requirements prescribed by the Standards of Quality.

E. The academic record of a student transferring from other Virginia public schools shall be sent directly to the school receiving the student upon request of the receiving school in accordance with the provisions of the 8VAC20-150, Management of the Student's Scholastic Record in the Public Schools of Virginia. The State Testing Identifier (STI) for students who transfer into a Virginia public school from another Virginia public school shall be retained by the receiving school.

F. The academic record of a student transferring into Virginia public schools from other than a Virginia public school shall be evaluated to determine the number of standard units of credit that have been earned, including credit from schools outside the United States, and the number of verified units of credit needed to graduate in accordance with subsection G of this section. Standard units of credit also shall be accepted for courses satisfactorily completed in accredited colleges and universities when the student has been given credit by the previous school attended.

Students transferring above the tenth grade from schools or other education programs that do not require or give credit for health and physical education shall not be required to take these courses to meet graduation requirements.

G. Students entering a Virginia public high school for the first time after the tenth grade shall earn as many credits as possible toward the graduation requirements prescribed in 8VAC20-131-50. However, schools may substitute courses required in other states in the same content area if the student is unable to meet the specific content requirements of 8VAC20-131-50 without taking a heavier than normal course load in any semester, by taking summer school, or by taking courses after the time when he otherwise would have graduated. In any event, no such student shall earn fewer than the following number of verified units, nor shall such students be required to take SOL tests or additional tests as defined in 8VAC20-131-110 for verified units of credit in courses previously completed at another school or program of study, unless necessary to meet the requirements listed in subdivisions 1 and 2 of this subsection:

1. For a Standard Diploma or Standard Technical Diploma:

- a. Students entering a Virginia high school for the first time during the ninth grade or at the beginning of the tenth grade shall earn credit as prescribed in 8VAC20-131-50;
- b. Students entering a Virginia high school for the first time during the tenth grade or at the beginning of the eleventh grade shall earn a minimum of four verified units of credit: one each in English, mathematics, history, and science. Students who complete a career and

technical education program sequence may substitute a certificate, occupational competency credential or license for either a science or history and social science verified credit pursuant to 8VAC20-131-50; and

c. Students entering a Virginia high school for the first time during the eleventh grade or at the beginning of the twelfth grade shall earn a minimum of two verified units of credit: one in English and one of the student's own choosing.

2. For an Advanced Studies Diploma or Advanced Technical Diploma:

a. Students entering a Virginia high school for the first time during the ninth grade or at the beginning of the tenth grade shall earn credit as prescribed in 8VAC20-131-50;

b. Students entering a Virginia high school for the first time during the tenth grade or at the beginning of the eleventh grade shall earn a minimum of six verified units of credit: two in English and one each in mathematics, history, and science and one of the student's own choosing; and

c. Students entering a Virginia high school for the first time during the eleventh grade or at the beginning of the twelfth grade shall earn a minimum of four verified units of credit: one in English and three of the student's own choosing.

H. Students entering a Virginia high school for the first time after the first semester of their eleventh grade year must meet the requirements of subdivision G 1 c or G 2 c of this section. Students transferring after 20 instructional hours per course of their senior or twelfth grade year shall be given every opportunity to earn a Standard, Standard Technical, Diploma or an Advanced Studies Diploma, Advanced Technical, or Modified Standard Diploma. If it is not possible for the student to meet the requirements for a diploma, arrangements should be made for the student's previous school to award the diploma. If these arrangements cannot be made, a waiver of the verified unit of credit requirements may be available to the student. The Department of Education may grant such waivers upon request by the local school board in accordance with guidelines prescribed by the Board of Education.

I. Any local school division receiving approval to increase its course credit requirements for a diploma may not deny either the Standard, Standard Technical, Diploma or the Advanced Studies Diploma, Advanced Technical, or Modified Standard Diploma to any transfer student who has otherwise met the requirements contained in these standards if the transfer student can only meet the division's additional requirements by taking a heavier than normal course load in any semester, by taking summer school, or by taking courses after the time when he otherwise would have graduated.

J. The transcript of a student who graduates or transfers from a Virginia secondary school shall conform to the

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requirements of 8VAC20-160, Regulations Governing Secondary School Transcripts.

K. The accreditation status of a high school shall not be included on the student transcript provided to colleges, universities, or employers. The board expressly states that any student who has met the graduation requirements established in 8VAC20-131-50 and has received a Virginia diploma holds a diploma that should be recognized as equal to any other Virginia diploma of the same type, regardless of the accreditation status of the student's high school. It is the express policy of the board that no student shall be affected by the accreditation status of the student's school. The board shall take appropriate action, from time to time, to ensure that no student is affected by the accreditation status of the student's school.

8VAC20-131-110. Standard and verified units of credit.

A. The standard unit of credit for graduation shall be based on a minimum of 140 clock hours of instruction and successful completion of the requirements of the course. When credit is awarded in less than whole units, the increment awarded must be no greater than the fractional part of the 140 hours of instruction provided. If a school division elects to award credit on a basis other than the 140 clock hours of instruction required for a standard unit of credit defined in this subsection, the local school division shall develop a written policy approved by the superintendent and school board ~~which that~~ ensures:

1. That the content of the course for which credit is awarded is comparable to 140 clock hours of instruction; and
2. That upon completion, the student will have met the aims and objectives of the course.

B. A verified unit of credit for graduation shall be based on a minimum of 140 clock hours of instruction, successful completion of the requirements of the course, and the achievement by the student of a passing score on the end-of-course SOL test for that course or additional tests as described in this subsection. A student may also earn a verified unit of credit by the following methods:

1. In accordance with the provisions of the Standards of Quality, students may earn a standard and verified unit of credit for any elective course in which the core academic SOL course content has been integrated and the student passes the related end-of-course SOL test. Such course and test combinations must be approved by the Board of Education.
2. Upon the recommendation of the division superintendent and demonstration of mastery of course content and objectives, qualified students may receive a standard unit of credit and be permitted to sit for the relevant SOL test to earn a verified credit without having to meet the 140-clock-hour requirement.

3. Students who do not pass Standards of Learning tests in science or history and social science may receive locally awarded verified credits from the local school board in accordance with criteria established in guidelines adopted by the Board of Education.

C. The Board of Education may from time to time approve additional tests for the purpose of awarding verified credit. Such additional tests, which enable students to earn verified units of credit, must, at a minimum, meet the following criteria:

1. The test must be standardized and graded independently of the school or school division in which the test is given;
2. The test must be knowledge based;
3. The test must be administered on a multistate or international basis, or administered as part of another state's accountability assessment program; and
4. To be counted in a specific academic area, the test must measure content that incorporates or exceeds the SOL content in the course for which verified credit is given.

The Board of Education will set the score that must be achieved to earn a verified unit of credit on the additional test options.

D. With such funds as are appropriated by the General Assembly, the Board of Education will provide opportunities for students who meet criteria adopted by the board to have an expedited retake of a SOL test to earn verified credit ~~or to meet literacy and numeracy requirements for the Modified Standard Diploma.~~

Part VII

School and Community Communications

8VAC20-131-270. School and community communications.

A. Each school shall promote communication and foster mutual understanding with parents and the community. Each school shall:

1. Involve parents, citizens, community agencies, and representatives from business and industry in developing, disseminating, and explaining the biennial school plan; in advisory committees; in curriculum studies; and in evaluating the educational program.
2. Provide annually to the parents and the community the School Performance Report Card in a manner prescribed by the board. The information contained therein will be for the most recent three-year period. Such information shall include but not be limited to:
 - a. Virginia assessment program results by percentage of participation and proficiency and disaggregated by student subgroups.
 - b. The accreditation rating earned by the school.
 - c. Attendance rates for students.

d. Information related to school safety to include, but not limited to, incidents of crime and violence.

e. Information related to qualifications and educational attainment of the teaching staff.

f. In addition, secondary schools' School Performance Report Cards shall include the following:

(1) Advanced Placement (AP) information to include percentage of students who take AP courses and percentage of students who take AP tests;

(2) International Baccalaureate (IB) and Cambridge course information to include percentage of students who are enrolled in IB or Cambridge programs and percentage of students who receive IB or Cambridge Diplomas;

(3) College-level course information to include percentage of students who take college-level courses including dual enrollment courses;

(4) Number and percentage of (i) graduates by diploma type as prescribed by the Board of Education, (ii) certificates awarded to the senior class including GED credentials, and (iii) students who do not complete high school;

(5) As a separate category on the school report card, the number of students obtaining board-approved industry certifications, and passing state licensure examinations, national occupational competency assessments and Virginia workplace readiness skills assessments while still in high school and the number of career and technical education completers who graduated; and

(6) Number and percentage of drop-outs.

3. Cooperate with business and industry in formulating career and technical educational programs and conducting joint enterprises involving personnel, facilities, training programs, and other resources.

4. Encourage and support the establishment and/or continuation of a parent-teacher association or other organization and work cooperatively with it.

B. At the beginning of each school year, each school shall provide to its students' parents or guardians information on the availability of and source for receiving:

1. The learning objectives developed in accordance with the provisions of 8VAC20-131-70 to be achieved at their child's grade level or, in high school, a copy of the syllabus for each of their child's courses, and a copy of the school division promotion, retention, and remediation policies;

2. The Standards of Learning applicable to the child's grade or course requirements and the approximate date and potential impact of the child's next SOL testing; and

3. An annual notice to students in all grade levels of all requirements for Standard, ~~Standard Technical, Diploma and Advanced Studies, Advanced Technical and Modified Standard Diplomas~~ Diploma, and the board's policies on promotion and retention as outlined in 8VAC20-131-30.

The division superintendent shall report to the department compliance with this subsection through the preaccreditation eligibility procedures in 8VAC20-131-290.

Part VIII

School Accreditation

8VAC20-131-280. Expectations for school accountability.

A. Schools will be accredited annually based on compliance with preaccreditation eligibility requirements and achievement of the school accountability requirements of 8VAC20-131-300 C.

B. Each school shall be accredited based, primarily, on achievement of the criteria established in 8VAC20-131-30 and in 8VAC20-131-50 as specified below:

1. The percentage of students passing the Virginia assessment program tests in the four core academic areas administered in the school with the accreditation rating calculated on a trailing three-year average that includes the current year scores and the scores from the two most recent years in each applicable academic area, or on the current year's scores, whichever is higher.

2. The percentage of students graduating from or completing high school based on a graduation and completion index prescribed by the Board of Education. The accreditation rating of any school with a twelfth grade shall be determined based on achievement of required SOL pass rates and percentage points on the board's graduation and completion index. School accreditation shall be determined by the school's current year index points or a trailing three-year average of index points that includes the current year and the two most recent years, whichever is higher. The Board of Education's graduation and completion index shall include weighted points for diploma graduates (100 points), GED recipients (75 points), students not graduating but still in school (70 points), and students earning certificates of program completion (25 points). The Board of Education's graduation and completion index shall account for all students in the graduating class's ninth-grade cohort, plus students transferring in, minus students transferring out and deceased students. Those students who are not included in one of the preceding categories will also be included in the index.

3. The number of students who successfully complete a remediation recovery program.

4. Schools, with grade configurations that do not house a grade or offer courses for which SOL tests or additional tests approved by the Board of Education as outlined in 8VAC20-131-110 are administered, will be paired with another school in the division housing one or more of the grades in which SOL tests are administered. The pairing of such schools will be made upon the recommendation of the local superintendent. The schools should have a "feeder" relationship and the grades should be contiguous.

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C. Subject to the provisions of 8VAC20-131-350, the governing school board of special purpose schools such as those provided for in § 22.1-26 of the Code of Virginia, Governor's schools, special education schools, alternative schools, or career and technical schools that serve as the student's school of principal enrollment may seek approval of an alternative accreditation plan from the Board of Education. Schools offering alternative education programs and schools with a graduation cohort of 50 or fewer students as defined by the graduation rate formula adopted by the board may request that the board approve an alternative accreditation plan to meet the graduation and completion index benchmark. Special purpose schools with alternative accreditation plans shall be evaluated on standards appropriate to the programs offered in the school and approved by the board prior to August 1 of the school year for which approval is requested. Any student graduating from a special purpose school with a ~~Standard, Standard Technical, Diploma or an Advanced Studies, Advanced Technical, or Modified Standard~~ Diploma must meet the requirements prescribed in 8VAC20-131-50.

In addition, pursuant to § 22.1-253.13:3 of the Code of Virginia, any school board, on behalf of one or more of its schools, may request the Board of Education for approval of an Individual School Accreditation Plan for the evaluation of the performance of one or more of its schools as authorized for special purpose schools.

D. When calculating the passing rates on Virginia assessment program tests for the purpose of school accreditation, the following tolerances for limited English proficient (LEP) and transfer students will apply:

1. The scores of LEP students enrolled in Virginia public schools fewer than 11 semesters may be removed from the calculation used for the purpose of school accreditation required by 8VAC20-131-280 B and 8VAC20-131-300 C. Completion of a semester shall be based on school membership days. Membership days are defined as the days the student is officially enrolled in a Virginia public school, regardless of days absent or present. For a semester to count as a completed semester, a student must have been in membership for a majority of the membership days of the semester. These semesters need not be consecutive.
2. In accordance with the provisions of 8VAC20-131-30, all students who transfer into Virginia public schools are expected to take and pass all applicable SOL tests in the content areas in which they receive instruction.
3. All students who transfer within a school division shall have their scores counted in the calculation of the school's accreditation rating. Students who transfer into a Virginia school from home instruction, or from another Virginia school division, another state, or another country, in grades kindergarten through 8 shall be expected to take all applicable SOL tests or additional tests approved by the board as outlined in 8VAC20-131-110. If the transfer takes place after the 20th instructional day following the opening

of school, the scores on these tests may be used in calculating school accreditation ratings.

4. Students who transfer into a Virginia middle or high school from home instruction, or from another state or country, and enroll in a course for which there is an end-of-course SOL test, shall be expected to take the test or additional tests for that course approved by the board as outlined in 8VAC20-131-110. If the transfer takes place after 20 instructional hours per course have elapsed following the opening of school or beginning of the semester, if applicable, the scores on those tests may be used in calculating school accreditation ratings in the year the transfer occurs.

5. Students who enroll on the first day of school and subsequently transfer to a school outside of the division for a total amount of instructional time equal to or exceeding 50% of a current school year or semester, whether the transfer was a singular or multiple occurrence, and return during the same school year shall be expected to take any applicable SOL test. The scores of those tests may be used in calculating the school accreditation rating in the year in which the transfers occur.

E. The Board of Education may adopt special provisions related to the administration and use of any Virginia assessment program test in a content area. The Board of Education may adopt special provisions related to the administration and use of the graduation and completion index, as prescribed by the board. The Board of Education may also alter the inclusions and exclusions from the accreditation calculations by providing adequate notice to local school boards. The board may add new tests or discontinue the use of existing tests in the Virginia Assessment Program by providing adequate notice to local school boards.

F. As a prerequisite to the awarding of an accreditation rating as defined in 8VAC20-131-300, each new or existing school shall document, in a manner prescribed by the board, the following: (i) the division's promotion/retention policies developed in accordance with the requirements of 8VAC20-131-30, (ii) compliance with the requirements to offer courses that will allow students to complete the graduation requirements in 8VAC20-131-50, (iii) the ability to offer the instructional program prescribed in 8VAC20-131-70 through 8VAC20-131-100, (iv) the leadership and staffing requirements of 8VAC20-131-210 through 8VAC20-131-240, and (v) the facilities and safety provisions of 8VAC20-131-260. The division superintendent shall report to the department compliance with this subsection through the preaccreditation eligibility procedures in 8VAC20-131-290.

8VAC20-131-360. Effective date.

A. The provisions in 8VAC20-131-30 B relating to double testing and the provisions in 8VAC20-131-60 C relating to Virtual Virginia shall become effective July 31, 2009.

B. Graduation requirements prescribed in 8VAC20-131-50 B and ~~D C~~ for the Standard Diploma and the Advanced Studies Diploma shall become effective with the ninth-grade class of ~~2011-2012~~ 2013-2014.

~~C. Graduation requirements prescribed in 8VAC20-131-50 C and E shall become effective with the ninth grade class of 2012-2013.~~

~~D. C.~~ Schools with a graduating class shall meet prescribed thresholds on a graduation and completion rate index as prescribed in 8VAC20-131-280 and 8VAC20-131-300 for accreditation ratings earned in 2010-2011 and awarded in 2011-2012.

~~E. D.~~ Accreditation ratings prescribed in 8VAC20-131-300 C 1 a shall become effective with tests administered in 2010-2011 and 2011-2012 for ratings awarded in 2011-2012 and 2012-2013.

~~F. E.~~ Accreditation ratings prescribed in 8VAC20-121-300 C 1 c shall become effective with tests administered in 2012-2013 for ratings awarded in 2013-2014 and beyond.

~~G. F.~~ The Academic and Career Plan prescribed in 8VAC20-131-140 shall become effective in 2013-2014.

~~H. G.~~ Unless otherwise specified, the remainder of these regulations shall be effective beginning with the 2011-2012 academic year.

VA.R. Doc. No. R13-3304; Filed October 14, 2014, 11:17 a.m.



TITLE 12. HEALTH

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Emergency Regulation

Title of Regulation: **12VAC30-120. Waivered Services (amending 12VAC30-120-1000; adding 12VAC30-120-1012, 12VAC30-120-1062, 12VAC30-120-1072, 12VAC30-120-1082).**

Statutory Authority: § 32.1-325 of the Code of Virginia; 42 USC § 1396.

Effective Dates: November 1, 2014, through April 1, 2016.

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.

Preamble:

Section 2.2-4011 of the Code of Virginia states that agencies may adopt emergency regulations in situations in which Virginia statutory law or the appropriation act or federal law or federal regulation requires that a regulation be effective in 280 days or less from its enactment, and the

regulation is not exempt under the provisions of § 2.2-4006 A 4 of the Code of Virginia. Item 301 III of Chapter 2 of the 2014 Acts of the Assembly, Special Session I, authorizes the Department of Medical Assistance Services to establish a 25% higher reimbursement rate, within the intellectual disability (ID) waiver program, for congregate residential services for individuals with complex medical or behavioral needs currently residing in an institution and unable to transition to integrated settings in the community due to the need for services that cannot be provided within the maximum allowable rate or for individuals whose needs present imminent risk of institutionalization, and enhanced waiver services are needed beyond those available with the maximum allowable rate. The amendments conform regulation to these requirements.

Part X

Intellectual Disability Waiver

Article 1

Definitions and General Requirements

12VAC30-120-1000. Definitions.

"AAIDD" means the American Association on Intellectual and Developmental Disabilities.

"Activities of daily living" or "ADLs" means personal care tasks, e.g., bathing, dressing, toileting, transferring, and eating/feeding. An individual's degree of independence in performing these activities is a part of determining appropriate level of care and service needs.

"Agency-directed model" means a model of service delivery where an agency is responsible for providing direct support staff, for maintaining individuals' records, and for scheduling the dates and times of the direct support staff's presence in the individuals' homes.

"ADA" means the American with Disabilities Act pursuant to 42 USC § 12101 et seq.

"Appeal" means the process used to challenge actions regarding services, benefits, and reimbursement provided by Medicaid pursuant to 12VAC30-110 and 12VAC30-20-500 through 12VAC30-20-560.

"Applicant" means a person (or his representative acting on his behalf) who has applied for or is in the process of applying for and is awaiting a determination of eligibility for admission to a home and community-based waiver or is on the waiver waiting list waiting for a slot to become available.

"Assistive technology" or "AT" means specialized medical equipment and supplies, including those devices, controls, or appliances specified in the Individual Support Plan but not available under the State Plan for Medical Assistance, which enable individuals to increase their abilities to perform ADLs, or to perceive, control, or communicate with the environment in which they live, or that are necessary to the proper functioning of the specialized equipment.

"Barrier crime" means those crimes listed in §§ 32.1-162.9:1 and 63.2-1719 of the Code of Virginia.

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"Behavioral health authority" or "BHA" means the local agency, established by a city or county under § 37.2-100 of the Code of Virginia that plans, provides, and evaluates mental health, intellectual disability (ID), and substance abuse services in the locality that it serves.

"Behavioral specialist" means a person who possesses any of the following credentials: (i) endorsement by the Partnership for People with Disabilities at Virginia Commonwealth University as a positive behavioral supports facilitator; (ii) board-certification as a behavior analyst (BCBA) or board-certification as an associate behavior analyst (BCABA); or (iii) licensure by the Commonwealth as either a psychologist, a licensed professional counselor (LPC), a licensed clinical social worker (LCSW), or a psychiatric clinical nurse specialist.

"CMS" means the Centers for Medicare and Medicaid Services, which is the unit of the federal Department of Health and Human Services that administers the Medicare and Medicaid programs.

"Case management" means the assessing and planning of services; linking the individual to services and supports identified in the Individual Support Plan; assisting the individual directly for the purpose of locating, developing, or obtaining needed services and resources; coordinating services and service planning with other agencies and providers involved with the individual; enhancing community integration; making collateral contacts to promote the implementation of the Individual Support Plan and community integration; monitoring to assess ongoing progress and ensuring services are delivered; and education and counseling that guides the individual and develops a supportive relationship that promotes the Individual Support Plan.

"Case manager" means the person who provides case management services on behalf of the community services board or behavioral health authority, as either an employee or a contractor, possessing a combination of (ID) work experience and relevant education that indicates that the individual possesses the knowledge, skills, and abilities as established by DMAS in 12VAC30-50-450.

"Community services board" or "CSB" means the local agency, established by a city or county or combination of counties or cities under Chapter 5 (§ 37.2-500 et seq.) of Title 37.2 of the Code of Virginia, that plans, provides, and evaluates mental health, ID, and substance abuse services in the jurisdiction or jurisdictions it serves.

"Companion" means a person who provides companion services for compensation by DMAS.

"Companion services" means nonmedical care, support, and socialization provided to an adult (ages 18 years and over). The provision of companion services does not entail routine hands-on care. It is provided in accordance with a therapeutic outcome in the Individual Support Plan and is not purely diversional in nature.

"Complex behavioral needs" means conditions requiring exceptional supports in order to respond to the individual's significant safety risk to self or others and documented by the Supports Intensity Scale (SIS) Virginia Supplemental Risk Assessment form (2010) as described in 12VAC30-120-1012.

"Complex medical needs" means conditions requiring exceptional supports in order to respond to the individual's significant health or medical needs requiring frequent hands-on care and medical oversight and documented by the Supports Intensity Scale (SIS) Virginia Supplemental Risk Assessment form (2010) as described in 12VAC30-120-1012.

"Comprehensive assessment" means the gathering of relevant social, psychological, medical, and level of care information by the case manager and is used as a basis for the development of the Individual Support Plan.

"Congregate residential support" or "CRS" means those supports in which the residential support services provider renders primary care (room, board, general supervision) and residential support services to the individual in the form of continuous (up to 24 hours per day) services performed by paid staff who shall be physically present in the home. These supports may be provided individually or simultaneously to more than one individual living in that home, depending on the required support. These supports are typically provided to an individual living (i) in a group home, (ii) in the home of the ID Waiver services provider (such as adult foster care or sponsored residential), or (iii) in an apartment or other home setting.

"Consumer-directed model" means a model of service delivery for which the individual or the individual's employer of record, as appropriate, is responsible for hiring, training, supervising, and firing of the person or persons who render the direct support or services reimbursed by DMAS.

"Crisis stabilization" means direct intervention to individuals with ID who are experiencing serious psychiatric or behavioral challenges that jeopardize their current community living situation, by providing temporary intensive services and supports that avert emergency psychiatric hospitalization or institutional placement or prevent other out-of-home placement. This service shall be designed to stabilize the individual and strengthen the current living situation so the individual can be supported in the community during and beyond the crisis period.

"DBHDS" means the Department of Behavioral Health and Developmental Services.

"DBHDS staff" means persons employed by or contracted with DBHDS.

"DMAS" means the Department of Medical Assistance Services.

"DMAS staff" means persons employed by or contracted with DMAS.

"DRS" means the Department of Rehabilitative Services.

"Day support" means services that promote skill building and provide supports (assistance) and safety supports for the acquisition, retention, or improvement of self-help, socialization, and adaptive skills, which typically take place outside the home in which the individual resides. Day support services shall focus on enabling the individual to attain or maintain his highest potential level of functioning.

"Developmental risk" means the presence before, during, or after an individual's birth, of conditions typically identified as related to the occurrence of a developmental disability and for which no specific developmental disability is identifiable through existing diagnostic and evaluative criteria.

"Direct marketing" means either (i) conducting directly or indirectly door-to-door, telephonic, or other "cold call" marketing of services at residences and provider sites; (ii) mailing directly; (iii) paying "finders' fees"; (iv) offering financial incentives, rewards, gifts, or special opportunities to eligible individuals and the individual's family/caregivers, as appropriate, as inducements to use the providers' services; (v) continuous, periodic marketing activities to the same prospective individual and the individual's family/caregiver, as appropriate - for example, monthly, quarterly, or annual giveaways as inducements to use the providers' services; or (vi) engaging in marketing activities that offer potential customers rebates or discounts in conjunction with the use of the providers' services or other benefits as a means of influencing the individual's and the individual's family/caregivers, as appropriate, use of the providers' services.

"Employer of record" or "EOR" means the person who performs the functions of the employer in the consumer directed model. The EOR may be the individual enrolled in the waiver, or a family member, caregiver or another person, as appropriate, when the individual is unable to perform the employer functions.

"Enroll" means that the individual has been determined by the case manager to meet the level of functioning requirements for the ID Waiver and DBHDS has verified the availability of an ID Waiver slot for that individual. Financial eligibility determinations and enrollment in Medicaid are set out in 12VAC30-120-1010.

"Entrepreneurial model" means a small business employing a shift of eight or fewer individuals who have disabilities and usually involves interactions with the public and coworkers who do not have disabilities.

"Environmental modifications" or "EM" means physical adaptations to a primary place of residence, primary vehicle, or work site (when the work site modification exceeds reasonable accommodation requirements of the Americans with Disabilities Act) that are necessary to ensure the individual's health and safety or enable functioning with greater independence when the adaptation is not being used to bring a substandard dwelling up to minimum habitation

standards. Such EM shall be of direct medical or remedial benefit to the individual.

"EPSDT" means the Early Periodic Screening, Diagnosis and Treatment program administered by DMAS for children under the age of 21 according to federal guidelines (that prescribe preventive and treatment services for Medicaid eligible children) as defined in 12VAC30-50-130.

"Exceptional reimbursement rate" or "exceptional rate" means a rate of reimbursement for congregate residential supports paid to providers who qualify to receive the exceptional rate set out in 12VAC30-120-1062.

"Exceptional supports" or "exceptional support services" means a qualifying level of supports, as more fully described in 12VAC30-120-1012, that are medically necessary for individuals with complex medical or behavioral needs, or both, to safely reside in a community setting. The need for exceptional supports is demonstrated when the funding required to meet the individual's needs has been expended on a consistent basis by providers in the past 90 days for medical or behavioral supports, or both, over and above the current maximum allowable CRS rate in order to support the individual in a manner that assures his health and safety.

"Exceptional Supports and Reimbursement Rate Review Committee" or "review committee" means DBHDS staff, including a trained SIS® specialist approved by DBHDS, a behavior specialist, a registered nurse, and a masters level social worker, and other staff as may be otherwise constituted by DBHDS, who will evaluate and make a determination about applications for the congregate residential support services and CRS exceptional reimbursement rate for compliance with regulatory requirements.

"Fiscal employer/agent" means a state agency or other entity as determined by DMAS to meet the requirements of 42 CFR 441.484 and the Virginia Public Procurement Act (Chapter 43 (§ 2.2-4300 et seq.) of Title 2.2 of the Code of Virginia).

"Freedom of choice" means the right afforded an individual who is determined to require a level of care specified in a waiver to choose (i) either institutional or home and community-based services provided there are available CMS-allocated and state-funded slots; (ii) providers of services; and (iii) waiver services as may be limited by medical necessity.

"Health planning region" or "HPR" means the federally designated geographical area within which health care needs assessment and planning takes place, and within which health care resource development is reviewed.

"Health, safety, and welfare standard" means that an individual's right to receive a waiver service is dependent on a finding that the individual needs the service, based on appropriate assessment criteria and a written individual plan for supports, and that services can be safely provided in the community.

"Home and community-based waiver services" or "waiver services" means the range of community services approved

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by the CMS, pursuant to § 1915(c) of the Social Security Act, to be offered to persons as an alternative to institutionalization.

"IDOLS" means Intellectual Disability Online System.

"In-home residential support services" means support provided in a private residence by a DBHDS-licensed residential provider to an individual enrolled in the waiver to include: (i) skill building and supports and safety supports to enable individuals to maintain or improve their health; (ii) developing skills in daily living; (iii) safely using community resources; (iv) being included in the life of the community and home; (v) developing relationships; and (vi) participating as citizens of the community. In-home residential support services shall not replace the primary care provided to the individual by his family and caregiver but shall be supplemental to it.

"Incremental step down provisions" means procedures normally found in plans for supports in which an individual's supports are gradually altered or reduced based upon progress towards meeting the goals of the individual's behavior plan.

"Individual" means the person receiving the services or evaluations established in these regulations.

"Individual Support Plan" or "ISP" means a comprehensive plan that sets out the supports and actions to be taken during the year by each service provider, as detailed in the provider's Plan for Supports, to achieve desired outcomes. The Individual Support Plan shall be developed by the individual enrolled in the waiver, the individual's family/caregiver, as appropriate, other service providers such as the case manager, and other interested parties chosen by the individual, and shall contain essential information, what is important to the individual on a day-to-day basis and in the future, and what is important for the individual to be healthy and safe as reflected in the Plan for Supports. The Individual Support Plan is known as the Consumer Service Plan in the Day Support Waiver.

"Instrumental activities of daily living" or "IADLs" means tasks such as meal preparation, shopping, housekeeping, laundry, and money management.

"Intellectual disability" or "ID" means a disability as defined by the American Association on Intellectual and Developmental Disabilities (AAIDD) in the Intellectual Disability: Definition, Classification, and Systems of Supports (11th edition, 2010).

~~"ICF/IID"~~ "ICF/IID" means a facility or distinct part of a facility certified by the Virginia Department of Health as meeting the federal certification regulations for an Intermediate Care Facility for ~~the Intellectually Disabled~~ individuals with intellectual disability and persons with related conditions and that addresses the total needs of the residents, which include physical, intellectual, social, emotional, and habilitation providing active treatment as defined in 42 CFR 435.1010 and 42 CFR 483.440.

"Licensed practical nurse" or "LPN" means a person who is licensed or holds multi-state licensure privilege pursuant to Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia to practice practical nursing as defined.

"Medicaid Long-Term Care Communication Form" or "DMAS-225" means the form used by the case manager to report information about changes in an individual's situation.

"Medically necessary" means an item or service provided for the diagnosis or treatment of an individual's condition consistent with community standards of medical practice as determined by DMAS and in accordance with Medicaid policy.

"Parent" or "parents" means a person or persons who is or are biologically or naturally related, a foster parent, or an adoptive parent to the individual enrolled in the waiver.

"Participating provider" means an entity that meets the standards and requirements set forth by DMAS and has a current, signed provider participation agreement with DMAS.

"Pend" means delaying the consideration of an individual's request for services until all required information is received by DBHDS.

"Person-centered planning" means a fundamental process that focuses on the needs and preferences of the individual to create an Individual Support Plan that shall contain essential information, a personal profile, and desired outcomes of the individual to be accomplished through waiver services and included in the providers' Plans for Supports.

"Personal assistance services" means assistance with ADLs, IADLs, access to the community, self-administration of medication or other medical needs, and the monitoring of health status and physical condition.

"Personal assistant" means a person who provides personal assistance services.

"Personal emergency response system" or "PERS" means an electronic device and monitoring service that enable certain individuals at high risk of institutionalization to secure help in an emergency. PERS services shall be limited to those individuals who live alone or are alone for significant parts of the day and who have no regular caregiver for extended periods of time and who would otherwise require extensive routine supervision.

"Personal profile" means a point-in-time synopsis of what an individual enrolled in the waiver wants to maintain, change, or improve in his life and shall be completed by the individual and another person, such as his case manager or family/caregiver, chosen by the individual to help him plan before the annual planning meeting where it is discussed and finalized.

"Plan for Supports" means each service provider's plan for supporting the individual enrolled in the waiver in achieving his desired outcomes and facilitating the individual's health and safety. The Plan for Supports is one component of the Individual Support Plan. The Plan for Supports is referred to

as an Individual Service Plan in the Day Support and Individual and Family with Developmental Disability Services (IFDDS) Waivers.

"Prevocational services" means services aimed at preparing an individual enrolled in the waiver for paid or unpaid employment. The services do not include activities that are specifically job-task oriented but focus on concepts such as accepting supervision, attendance at work, task completion, problem solving, and safety. Compensation for the individual, if provided, shall be less than 50% of the minimum wage.

"Primary caregiver" means the primary person who consistently assumes the role of providing direct care and support of the individual enrolled in the waiver to live successfully in the community without compensation for providing such care.

"Qualified mental retardation professional" or "QMRP" for the purposes of the ID Waiver means the same as defined at 12VAC35-105-20.

"Qualifying individual" means an individual who has received a service authorization from DMAS or its service authorization contractor to receive exceptional supports.

"Registered nurse" or "RN" means a person who is licensed or holds multi-state licensure privilege pursuant to Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia to practice professional nursing.

"Residential support services" means support provided in the individual's home by a DBHDS-licensed residential provider or a VDSS-approved provider of adult foster care services. This service is one in which skill-building, supports, and safety supports are routinely provided to enable individuals to maintain or improve their health, to develop skills in daily living and safely use community resources, to be included in the community and home, to develop relationships, and to participate as citizens in the community.

"Respite services" means services provided to individuals who are unable to care for themselves, furnished on a short-term basis because of the absence or need for relief of those unpaid persons normally providing the care.

"Risk assessment" means an assessment that is completed by the case manager to determine areas of high risk of danger to the individual or others based on the individual's serious medical or behavioral factors. The required risk assessment for the ID Waiver shall be found in the state-designated assessment form which may be supplemented with other information. The risk assessment shall be used to plan risk mitigating supports for the individual in the Individual Support Plan.

"Safety supports" means specialized assistance that is required to assure the health and welfare of an individual.

"Service authorization" means the process of approving by either DMAS or its designated service authorization contractor, for the purpose of DMAS' reimbursement, the service for the individual before it is rendered.

"Service authorization for exceptional supports" means the process of approving an individual, by either DMAS or its designated service authorization contractor, for the purpose of receiving exceptional supports. Service authorization shall be obtained before exceptional supports to the individual are rendered.

"Services facilitation" means a service that assists the individual or the individual's family/caregiver, or EOR, as appropriate, in arranging for, directing, and managing services provided through the consumer-directed model of service delivery.

"Services facilitator" means the DMAS-enrolled provider who is responsible for supporting the individual or the individual's family/caregiver, or EOR, as appropriate, by collaborating with the case manager to ensure the development and monitoring of the CD Services Plan for Supports, providing employee management training, and completing ongoing review activities as required by DMAS for consumer-directed companion, personal assistance, and respite services.

"Significant change" means, but shall not be limited to, a change in an individual's condition that is expected to last longer than 30 calendar days but shall not include short-term changes that resolve with or without intervention, a short-term acute illness or episodic event, or a well-established, predictive, cyclical pattern of clinical signs and symptoms associated with a previously diagnosed condition where an appropriate course of treatment is in progress.

"Skilled nursing services" means both skilled and hands-on care, as rendered by either a licensed RN or LPN, of either a supportive or health-related nature and may include, but shall not be limited to, all skilled nursing care as ordered by the attending physician and documented on the Plan for Supports, assistance with ADLs, administration of medications or other medical needs, and monitoring of the health status and physical condition of the individual enrolled in the waiver.

"Slot" means an opening or vacancy in waiver services for an individual.

"State Plan for Medical Assistance" or "Plan" means the Commonwealth's legal document approved by CMS identifying the covered groups, covered services and their limitations, and provider reimbursement methodologies as provided for under Title XIX of the Social Security Act.

"Supports" means paid and nonpaid assistance that promotes the accomplishment of an individual's desired outcomes. There shall be three types of supports: (i) routine supports that assist the individual in daily activities; (ii) skill building supports that help the individual gain new abilities; and (iii) safety supports that are required to assure the individual's health and safety.

"Supported employment" means paid supports provided in work settings in which persons without disabilities are typically employed. Paid supports include skill-building

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supports related to paid employment, ongoing or intermittent routine supports, and safety supports to enable an individual with ID to maintain paid employment.

"Support plan" means the report of recommendations resulting from a therapeutic consultation.

"Supports Intensity Scale[®]" or "SIS[®]" means a tool, developed by the American Association on Intellectual and Developmental Disabilities that measures the intensity of an individual's support needs for the purpose of assessment, planning, and aligning resources to enhance personal independence and productivity.

"Therapeutic consultation" means covered services designed to assist the individual and the individual's family/caregiver, as appropriate, with assessments, plan design, and teaching for the purpose of assisting the individual enrolled in the waiver.

"Transition services" means set-up expenses as defined in 12VAC30-120-2010.

"VDSS" means the Virginia Department of Social Services.

12VAC30-120-1012. Individuals enrolled in the ID waiver who are receiving congregate residential support services and require exceptional levels of supports.

A. Exceptional supports shall be available for individuals who:

1. Are currently enrolled or are qualified to enroll in the ID waiver,
2. Are currently receiving or qualify to receive congregate residential support, and
3. Have complex medical or behavioral needs, or both, and who require additional staffing support or professional services enhancements (i.e., the involvement of medical or behavioral professionals).

B. In addition to the requirements in subsection A of this section, in order for an individual to qualify for the receipt of exceptional supports, the individuals shall either:

1. Currently reside in an institution, such as a training center or a nursing facility, and be unable to transition to integrated community settings because they cannot access sufficient community waiver supports due to their complex medical or behavioral needs, or both. In addition to meeting the requirements of this section, in order to qualify for exceptional support, case managers for an individual who is currently residing in a training center or nursing facility shall document in their service authorization request to DMAS or its service authorization contractor that, based on supports required by the individual in the last 90 days while he resided in a training center or nursing facility, the individual is unable to transition to the community. This inability to transition shall be due to the anticipated need for services that cannot be provided within the maximum allowable CRS rate upon discharge into the community, or

2. Currently reside in the community and their medical or behavioral needs, or both, present an imminent risk of institutionalization and an exceptional level of congregate residential supports is required to maintain these individuals in the community. In addition to meeting the requirements in subsection C of this section, in order to qualify for exceptional supports, individuals currently residing in the community shall provide, as a part of the service authorization request, documented evidence for the 90 days immediately prior to the exceptional supports request that one or more of the following has occurred:

- a. Funding has been expended on a consistent basis by providers in the past 90 days for medical or behavioral supports, or both, over and above the current maximum allowable CRS rate in order to assure the health and safety of the individual;
- b. The residential services plan for supports has been approved and authorized by DMAS or its service authorization contractor for the maximum number of hours of support, as in 24 hours per day seven days a week, yet the individual still remains at imminent risk of institutionalization;
- c. The staff to individual ratio has increased in order to properly support the individual (e.g., the individual requires a 2:1 staff to individual ratio for some or all of the time); or
- d. Available alternative community options have been explored and utilized but the individual still remains at imminent risk of institutionalization.

C. In addition to the requirements in subsections A and B of this section, in order to qualify for exceptional supports individuals shall have the following numbered assessment values on the most recently completed Supports Intensity Scale[®] (SIS) Virginia Supplemental Risk Assessment form (2010):

1. The individual requires frequent hands-on staff involvement to address critical health and medical needs (#1a), and the individual has medical care plans in place that are documented in the ISP process (#1c);
2. The individual has been found guilty of a crime or crimes related to severe community safety risk to others through the criminal justice system (#2a) (e.g., convicted of actual or attempted assault or injury to others, property destruction due to fire setting or arson, or sexual aggression) and the individual's severe community safety risk to others requires a specially controlled home environment, direct supervision at home or direct supervision in the community, or both, (#2b) and the individual has documented restrictions in place related to these risks through a legal requirement or order (#2c);
3. The individual has not been found guilty of a crime related to a severe community safety risk to others (such as actual or attempted assault or injury to others, property

destruction due to fire setting or arson, or sexual aggression) but displays the same severe community safety risk as a person found guilty through the criminal justice system (#3a) and the individual's severe community safety risk to others requires a specially controlled home environment, direct supervision at home or direct supervision in the community, or both (#3b) and the individual has documented restrictions in place related to these risks within the ISP process (#3c); or

4. The individual engages in self-directed destructiveness related to self-injury, pica (eating non-food substances), or suicide attempts, or all of these, with the intent to harm self (#4a), the individual's severe risk of injury to self currently requires direct supervision during all waking hours (#4b), and the individual has prevention and intervention plans in place that are documented within the ISP process (#4c); and

5. The individual demonstrates a score of 2 (extensive support needed) on any two items in the AAIDD Supports Intensity Scale[®] (version 2010) in either:

a. Section #3a Exceptional Medical and Behavioral Support Needs: Medical Supports Needed except for item 11 (seizure management) or item 15 (therapy services) or

b. Section #3b Exceptional Medical and Behavioral Support Needs: Behavioral Supports Needed except for item 12 (maintenance of mental health treatments).

D. The entire SIS[®] submitted as documentation in support of the individual's service authorization request for exceptional supports shall have been completed no more than six months prior to submission of the exceptional rate service authorization request.

E. The individual's case manager shall submit a service authorization request for exceptional supports to DMAS or its service authorization contractor, who shall make the final determination as to whether the individual qualifies for exceptional supports. If the service authorization request fails to demonstrate that the individual's support needs meet the criteria described in this section, service authorization shall be denied. Individuals may appeal the denial of a service authorization request for exceptional supports in accordance with the DMAS client appeal regulations, 12VAC30-110-10 through 12VAC30-110-370.

12VAC30-120-1062. Exceptional rate congregate residential supports provider requirements.

In addition to the general provider requirements set out in 12VAC30-120-1040, in order to qualify for exceptional rate reimbursement providers shall meet the requirements of this section.

A. Providers shall receive the exceptional rate only for exceptional supports provided to qualifying individuals. Providers shall not contest the determination that a given individual is not eligible for exceptional support services.

B. Providers requesting approval to provide and receive reimbursement for exceptional supports shall have a DBHDS license in good standing per 12VAC35-105. Neither provisional nor conditional licenses shall qualify a provider for the receipt of the exceptional rate. Providers shall demonstrate in writing on the exceptional rate application that they can meet the support needs of a specified qualifying individual through qualified staff trained to provide the extensive supports required by the qualified individual's exceptional support needs. Providers may qualify for exceptional rate reimbursement only when the CRS provider's staff (either employed or contracted) directly performs the support activity or activities required by a qualifying individual.

C. Providers shall work with local case managers in order to file their application for exceptional rate reimbursement. Provider requests for the exceptional rate shall be set out on the DBHDS-designated exceptional rate application and shall be directed to the CSB case manager for the qualifying individual requesting services from the provider. The qualifying individual's case manager shall consult with the DBHDS staff if the individual is currently residing in a training center. Case managers shall work directly with those qualifying individuals who are residing in the community. The case manager shall refer the provider's exceptional rate application to the DBHDS review committee, which shall make a determination on the application within 10 business days.

1. The review committee shall deny an exceptional rate application if it determines either:

a. That a provider has not demonstrated that it can safely meet the exceptional support needs of the qualifying individual,

b. That the provider's active protocols for the delivery of exceptional supports to the qualifying individual are not sufficient,

c. That the provider fails to meet the requirements of this section, or

d. That the application otherwise fails to support the payment of the exceptional rate.

2. If the review committee denies an exceptional rate application, it shall notify the provider in writing of such denial and the reason or reasons for the denial.

D. Providers requesting the exceptional reimbursement rate shall describe the exceptional supports they have the capacity to provide to a qualifying individual on the exceptional rate application. Providers shall ensure that their exceptional reimbursement rate application has been approved by DBHDS prior to submitting any claims for this exceptional rate. Payment at the exceptional reimbursement rate shall be made to the CRS provider effective the date of DBHDS approval of the provider's exceptional rate application and upon completion of the service authorization process for the

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individual, whichever comes later. Providers may appeal the denial of a request for the exceptional rate in accordance with the DMAS provider appeal regulations, 12VAC30-20-500 through 12VAC30-20-560.

E. Requirements for providers currently providing exceptional supports to qualifying individuals.

1. Providers, who have been approved to receive the exceptional rate and are currently supporting qualifying individuals, shall document in each of the qualifying individuals' plans for supports how that provider will respond to the individuals' specific exceptional needs. Providers shall update the plans for supports as necessary to reflect the current status of these individuals. Providers shall address each of the individuals' complex medical and behavioral support needs through specific and documented protocols that may include, for example, (i) employing additional staff to support the individual, or (ii) securing additional professional support enhancements, or both, beyond those planned supports reimbursed through the maximum allowable CRS rate. Providers shall document in a qualifying individual's record that the costs of such additional supports exceeds those covered by the standard CRS rate.

2. CRS providers delivering exceptional rate supports for qualifying individuals due to their medical support needs shall employ or contract with a registered nurse (RN) for the delivery of exceptional supports. The RN shall be licensed in the Commonwealth or hold multi-state licensure privilege pursuant to § 54.1-3000 et seq. of the Code of Virginia and shall have a minimum of two years of related clinical experience. This related clinical experience may include work in an acute care hospital, public health clinic, home health agency, rehabilitation hospital, nursing facility, or an ICF/IID. The RN shall administer or delegate in accordance with 18VAC90-20-430 through 18VAC90-20-460 the required complex medical supports.

a. All staff who will be supporting a qualifying individual shall receive individual-specific training regarding the individual's medical condition or conditions, medications (including training about side effects), risk factors, safety practices, procedures that staff are permitted to perform under nurse delegation, and any other training the RN deems necessary to enable the individual to be safely supported in the community. The provider shall arrange for the training to be provided by qualified professionals and document the training in the provider's record.

b. The RN shall also monitor the staff including, but not limited to, observing staff performing the needed complex medical supports.

3. Providers providing exceptional supports for qualifying individuals due to their behavior support needs shall consult with a qualified behavioral specialist. This qualified behavior specialist shall develop a behavior plan

based upon the qualifying individual's needs and train the provider's staff in its implementation consistent with the requirements defined in 12VAC30-120-1060. Both the behavior plan and staff receipt of training shall be documented in the provider's record.

4. Providers who will be supporting a qualifying individual with complex behavioral issues shall have training policies and procedures in place and demonstrate that staff has received appropriate training including, but not limited to, positive support strategies, in order to support an individual with mental illness, or behavioral challenges, or both.

a. All staff who will be supporting qualifying individuals shall be identified on the exceptional rate application with a written description of the staff's abilities to meet the needs of qualifying individuals and the training received related to such needs.

b. Providers shall ensure that the physical environment of the home is appropriate to accommodate the needs of qualifying individuals with respect to the behavioral and medical challenges typical to this population.

5. Providers shall have on file crisis stabilization plans for all qualifying individuals with complex behavioral needs. These plans shall provide direct interventions that avert emergency psychiatric hospitalizations or institutional placement and include appropriate admission to crisis response services that are provided in the Commonwealth. These plans shall be approved by DBHDS and reviewed by the review committee as set out in 12VAC30-120-1062.

6. The provider's and the case manager's records shall also contain the following for each qualifying individual to whom they are providing services:

a. The active protocol, for qualifying individuals currently enrolled in the ID waiver, that demonstrates extensive supports are being delivered in the areas of extensive support needs in the SIS[®]. For those qualifying individuals who are new to the waiver, a protocol shall be developed;

b. An ISP, developed by the qualifying individual's support team, that demonstrates the needed supports and contains support activities to address these; and

c. Evidence of the provider's ability to meet the qualifying individual's exceptional support needs, for all that apply: documentation of staff training, employment of or contract with an RN, involvement of a behavior or psychological consultant, or crisis team involvement, and other additional requirements as set forth in 12VAC30-120-1062.

12VAC30-120-1072. Exceptional CRS rate reimbursement for certain congregate residential support services.

A. CRS providers that obtain authorization to receive the exceptional reimbursement rate for qualifying individuals

TITLE 13. HOUSING

VIRGINIA HOUSING DEVELOPMENT AUTHORITY

Proposed Regulation

REGISTRAR'S NOTICE: The Virginia Housing Development Authority is claiming an exemption from the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia) pursuant to § 2.2-4002 A 4 of the Code of Virginia.

Title of Regulation: **13VAC10-190. Rules and Regulations for Qualified Mortgage Credit Certificate Programs (adding 13VAC10-190-10 through 13VAC10-190-200).**

Statutory Authority: § 36-55.30:3 of the Code of Virginia.

Public Hearing Information: November 17, 2014 - 10 a.m. - Virginia Housing Development Authority, 601 South Belvidere Street, Richmond, VA 23220

Public Comment Deadline: November 17, 2014.

Agency Contact: Paul M. Brennan, General Counsel, Virginia Housing Development Authority, 601 South Belvidere Street, Richmond, VA 23220, telephone (804) 343-5798, or email paul.brennan@vhda.com.

Summary:

The proposed regulations will govern how the Virginia Housing Development Authority awards and distributes mortgage credit certificates in accordance with all applicable laws and regulations for each mortgage credit certificate program it chooses to create pursuant to § 25 of the Internal Revenue Code (Title 26 of the United States Code).

CHAPTER 190

RULES AND REGULATIONS FOR QUALIFIED MORTGAGE CREDIT CERTIFICATE PROGRAMS

13VAC10-190-10. Definitions.

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

"Applicant" means the individual applying for a mortgage credit certificate.

"Authority" means the Virginia Housing Development Authority, a political subdivision of the Commonwealth of Virginia constituting a public instrumentality.

"Certificate credit rate" has the meaning set forth in IRC § 25.

"Certified indebtedness" has the meaning set forth in IRC § 25. It is the indebtedness or portion thereof that the applicant will incur to acquire his principal residence and that, in the determination of the authority, meets the requirements of IRC § 25 and will be used in calculating the amount of the potential tax credit under the mortgage credit certificate.

shall receive the rate only for services provided in accordance with a qualifying individual's Plan for Supports.

B. At any time that there is a significant change in the qualifying individual's medical or behavioral support needs, the provider shall notify the qualifying individual's case manager and document such changes in the qualifying individual's Plan for Supports. Upon receiving provider notification, the case manager shall confer with DBHDS about these changes to determine what modifications are indicated in the Plan for Supports, including whether or not the individual continues to qualify for receipt of the exceptional supports.

C. This exceptional rate shall be established in the DMAS fee schedule as posted on http://www.dmas.virginia.gov/Content/pgs/pr-ffs_new.aspx.

D. As of the effective date of this emergency regulation, this exceptional CRS rate reimbursement is 25% higher than the standard CRS rate.

12VAC30-120-1082. Exceptional rate utilization review.

A. In addition to the utilization review and level of care review requirements in 12VAC30-120-1080, the case manager shall conduct face-to-face monthly contacts with the qualifying individual.

B. The case manager shall provide to DBHDS updated versions of the required documentation consistent with the requirements of 12VAC30-120-1012 at least every three years or whenever there is a significant change in the qualifying individual's needs or status. The provider shall be responsible for transmitting this information to the case manager.

1. This updated version shall include:

a. A review of the qualifying individual's response to the provision of exceptional supports developed with the qualifying individual and the CRS provider.

b. A description of the incremental step-down provisions included in the qualifying individual's Plan for Supports.

2. The DBHDS review committee shall make a determination about the provider's continued eligibility for exceptional rate reimbursement for a given qualifying individual.

VA.R. Doc. No. R15-3839; Filed October 15, 2014, 3:23 p.m.



Regulations

"Commitment" means the obligation of the authority to provide a mortgage credit certificate to an eligible applicant pursuant to an approved application.

"Commitment term" means the period of time during which the applicant must close on his loan to be entitled to a mortgage credit certificate pursuant to his commitment.

"Executive director" means the executive director of the authority or any other officer or employee of the authority who is authorized to act on behalf of the director or the authority pursuant to a resolution of the board of the authority.

"Internal Revenue Code" or "IRC" means Title 26 of the United States Code, as the same may be amended from time to time.

"Loan" means any extension of credit that finances the purchase of and will be secured by a principal residence.

"Mortgage credit certificate" or "MCC" means a certificate issued by the authority pursuant to IRC § 25.

"Participating lender" means any person or organization that is legally authorized to engage in the business of making loans for the purchase of principal residences and meets the qualifications in this chapter to participate in the programs.

"Principal residence" means a dwelling that will be occupied as the primary residence of the purchaser, that will not be property held in a trade or business or as investment property, that is not a recreational or second home, and no part of which will be used for any business purposes for which expenses may be deducted for federal income tax purposes.

"Program" means a qualified mortgage credit certificate program as defined in IRC § 25, in particular IRC § 25(c)(2)(A).

"Private activity bonds" has the meaning set forth in IRC § 141.

13VAC10-190-20. Description of the program.

The authority may establish one or more programs pursuant to IRC § 25. Each program will be established by the authority when the executive director elects not to issue an amount of private activity bonds that the authority could have issued from its allocation of private activity bonds pursuant to IRC § 146 and to utilize that allocation to issue MCCs. Each instance of the executive director making that determination will result in a separate program.

13VAC10-190-30. Purpose, applicability, and scope of regulations.

A. All programs described in 13VAC10-190-20 and all of the MCCs issued by the authority pursuant to such programs are subject to this chapter.

B. This chapter is intended to provide a general description of the authority's requirements and processing and is not intended to include all actions involved or required in the processing and administration of MCCs. This chapter is subject to amendment by the authority at any time and may be

supplemented by policies, rules, and regulations adopted by the authority from time to time with respect to all of the programs.

C. Notwithstanding anything to the contrary in this chapter, the executive director is authorized with respect to any MCC program to waive or modify any provision of this chapter where deemed appropriate by him for good cause, to the extent not inconsistent with the IRC.

D. Notwithstanding anything to the contrary in this chapter, MCCs can only be issued when and to the extent permitted by the IRC and the applicable federal laws, rules, and regulations governing the issuance of MCCs.

E. Notwithstanding anything to the contrary in this chapter, the federal laws, rules, and regulations governing the MCCs shall control over any inconsistent provision in this chapter, and individuals to whom MCCs have been issued shall be entitled to the privileges and benefits thereof only to the extent permitted by the IRC.

F. Wherever appropriate in this chapter, the singular shall include the plural; the plural shall include the singular; and the masculine shall include the feminine.

13VAC10-190-40. Eligible persons.

The authority may issue an MCC to an individual only if he would be eligible to be a borrower of a tax exempt bond financed loan pursuant to 13VAC10-40-30, 13VAC10-40-40, 13VAC10-40-50, 13VAC10-40-70, 13VAC10-40-90, and 13VAC10-40-100.

13VAC10-190-50. Eligible properties.

The authority may issue an MCC to an individual only if his application for the MCC is based upon his purchasing a principal residence that would be eligible for a tax exempt bond financed loan pursuant to 13VAC10-40-40 through 13VAC10-40-80.

13VAC10-190-60. Eligible lenders.

The authority may issue an MCC to an individual only if his application for the MCC is based upon his obtaining a loan from a participating lender.

13VAC10-190-70. Eligible loans.

The authority may issue an MCC to an individual only if his application for the MCC is based upon a loan that:

1. Is not funded in whole or in part from the proceeds of a qualified mortgage bond or a qualified veteran's mortgage bond as defined in IRC § 143.
2. Is incurred by the applicant to acquire his principal residence.
3. Is not being assumed from another borrower, and
4. Is not a refinancing of other indebtedness of the applicant, except in the case of construction period loans, bridge loans, or similar temporary financing that has a term of 24 months or less.

13VAC10-190-80. Determination of the amount of each program.

The executive director shall determine the amount, if any, of private activity bonds that the authority will elect not to issue and the amount, if any, of each program (program amount) as determined pursuant to the applicable portions of 26 CFR 1.25-4T, 26 CFR 1.25-5T, and 26 CFR 1.25-7T, subject to revocation, in whole or in part, by the executive director pursuant to 26 CFR 1.25-4T(c)(3). Nothing contained in this chapter shall be construed to require the commitment for or issuance of any MCC or to entitle any applicant to an MCC if no program amount is available for such MCC.

13VAC10-190-90. Portions of each program amount to be set aside.

For each program, the executive director may set aside a portion of the program amount, in an amount determined by the executive director to be appropriate, that will not be used to issue MCCs until such time and in such amount as may be determined by the executive director to be appropriate to comply with the requirements of IRC § 25 and the related U.S. Department of the Treasury regulations.

13VAC10-190-100. Determination of certificate credit rate.

For each program, the executive director shall establish the certificate credit rate in accordance with the limits set by IRC § 25(d), subject to change from time to time as he shall deem necessary or appropriate to accomplish the purpose of the program. The certificate credit rate shall be specified on each MCC issued under the program.

13VAC10-190-110. Certification of lenders.

A. For each program, the executive director shall establish criteria for lenders to be approved by the authority as participating lenders, which criteria may include one or more of the following: (i) completion of required training; (ii) agreement to follow the authority's policies and procedures relating to the issuance of MCCs; (iii) agreement to be subject to penalties, including disqualification as participating lenders, or liabilities for violating the authority's policies and procedures; and (iv) payment of participation fees. The executive director may specify the circumstances under which the satisfaction of such criteria shall remain valid for subsequent programs.

B. In addition to the criteria in subsection A of this section, no lender may process applications for MCCs that is not (i) permitted by law to loan money for the acquisition of principal residences in Virginia, (ii) the lender that actually makes the loan for which the MCC is requested, and (iii) in good standing with all applicable licensing and regulatory authorities with jurisdiction over such lender.

C. Each participating lender shall execute such agreements and documents as the authority may require to participate in the programs and, in the event of any breach by such participating lender of any of the terms of any such agreement

or document, the participating lender may be terminated by the authority from participation in the programs.

13VAC10-190-120. Fees.

For each program, the executive director shall establish (i) the fees charged lenders to participate in such program and (ii) the fees charged each applicant for the processing of the application and the issuance of the applicant's MCC. The executive director may establish lower fees for participating lenders that are approved by the authority as loan originators under 13VAC10-40 and for MCC applicants whose loans will be purchased by the authority.

13VAC10-190-130. Terms of each program.

For each program, the executive director may establish a deadline for the receipt of applications for MCCs for any purpose determined by the executive director to be necessary or appropriate for the administration of the program, including so the authority can safeguard against issuing any MCCs after the expiration of its authority to do so pursuant to IRC § 25(e)(3)(B).

13VAC10-190-140. Priority of applications.

Subject to (i) the set asides described in 13VAC10-190-90 and 13VAC10-190-150 and (ii) the deadline for receipt of applications described in 13VAC10-190-130, the authority shall process applications in the order the authority receives them.

13VAC10-190-150. Targeted areas.

For each program, the authority may set aside 20% of the program amount for use in targeted areas, as specified by IRC § 25 and the related U.S. Department of the Treasury regulations for a period of one year from the date on which the MCCs under that program are first made available. In addition, the authority may take all other necessary steps to comply with the targeted area requirements imposed by IRC § 25 and the related U.S. Department of the Treasury regulations.

13VAC10-190-160. Discretion to allocate.

Notwithstanding anything to the contrary in this chapter, in administering each program, the executive director may make allocations and may impose limitations or restrictions on the allocation of MCCs in order to insure a broad geographic dispersal of MCCs throughout the Commonwealth of Virginia or to facilitate collaboration with other governmental entities of the Commonwealth of Virginia to increase the affordability of homeownership in Virginia.

13VAC10-190-170. MCCs not transferable.

No person to whom the authority issues an MCC may transfer his MCC to any other person.

13VAC10-190-180. Applications for MCCs.

1. Participating lenders shall forward to the authority, in the manner and procedure required by the authority, applications from borrowers applying for MCCs.

2. Except for borrowers whose loans are originated directly by the authority, the authority shall not accept applications directly from borrowers.

3. Applications for MCCs must include such forms, documents, information, and fees as the executive director may require. Such requirements may change for each program and may include documentation necessary for the authority to comply with reporting requirements imposed by the IRC, in addition to documentation necessary to determine the applicant's eligibility for an MCC. The authority may also require additional documentation and information regarding applicants that the executive director determines to be appropriate for measuring the performance of the program.

4. The authority shall review each application and, if the authority determines that the application complies with these rules and regulations and applicable federal laws, rules, and regulations, then the authority shall issue a commitment to the applicant, either directly or through the participating lender, with respect to such MCC.

5. The maximum principal amount, amortization period, and interest rate on the applicant's loan and such other terms, conditions, and requirements as the executive director deems necessary or appropriate shall be set forth in each commitment. Each commitment term shall be for a term of 60 days, except that the term may be extended for good cause in the sole discretion of the authority.

6. Based upon the application, this chapter, and all applicable federal laws, rules, and regulations, the authority shall determine whether an MCC shall be issued and shall determine the certificate credit rate and the certified indebtedness amount applicable to the MCC.

13VAC10-190-190. Issuance of an MCC.

The closing of the loan shall be consummated in accordance with the terms of the commitment. Upon receipt of such forms, documents, information, and fees as the executive director may require upon closing, the authority shall issue an MCC to the applicant. The MCC shall specify the certificate credit rate and the certified indebtedness amount and shall otherwise satisfy the requirements of 26 CFR 1.25-6T.

13VAC10-190-200. Compliance investigations.

After each MCC is issued, the authority shall have the right, but not the obligation, to investigate the facts and circumstances relating to any application and the issuance and use of the related MCC and, if there are proper grounds, to revoke the MCC and take other appropriate legal action.

VA.R. Doc. No. R15-4170; Filed October 9, 2014, 10:41 a.m.

TITLE 14. INSURANCE

STATE CORPORATION COMMISSION

Proposed Regulation

REGISTRAR'S NOTICE: The State Corporation Commission is claiming an exemption from the Administrative Process Act in accordance with § 2.2-4002 A 2 of the Code of Virginia, which exempts courts, any agency of the Supreme Court, and any agency that by the Constitution is expressly granted any of the powers of a court of record.

Title of Regulation: **14VAC5-200. Rules Governing Long-Term Care Insurance (amending 14VAC5-200-30, 14VAC5-200-40, 14VAC5-200-70, 14VAC5-200-75, 14VAC5-200-77, 14VAC5-200-100, 14VAC5-200-120, 14VAC5-200-150, 14VAC5-200-153, 14VAC5-200-183, 14VAC5-200-185; adding 14VAC5-200-125, 14VAC5-200-154, 14VAC5-200-195; repealing 14VAC5-200-20).**

Statutory Authority: §§ 12.1-13, 38.2-223, and 38.2-5202 of the Code of Virginia.

Public Hearing Information: A public hearing will be held upon request.

Public Comment Deadline: December 1, 2014.

Agency Contact: Robert Grissom, Chief Insurance Market Examiner, Bureau of Insurance, State Corporation Commission, P.O. Box 1157, Richmond, VA 23218, telephone (804) 371-9152, FAX (804) 371-9944, or email bob.grissom@scc.virginia.gov.

Summary:

The proposed amendments are submitted to address concerns regarding recent substantial premium rate increases implemented by insurers writing long-term care insurance in Virginia. The amendments, in part, incorporate recent revisions to the National Association of Insurance Commissioners (NAIC) Model Regulation, as well as the provisions of the NAIC Model Bulletin of Alternative Filing Requirements for Long-Term Care Premium Rate Increases, which applies to rate increases for pre-rate stability policies as well as post-rate stability policies that are currently in effect. The amendments include, among other things: (i) increased disclosure requirements regarding premium rate practices; (ii) an extension of the current 60-day rate increase notification to 75 days; (iii) a requirement that insurers file with the Bureau of Insurance the notice they will use to notify policyholders of rate increases; (iv) a requirement that premiums contain a composite margin for moderately adverse experience of no less than 10% of lifetime claims for initial filings; (v) requirements regarding annual rate certifications; (vi) the implementation of new standards for pre-rate stability policies; (vii) the establishment of standards for the allowance of a single rate increase or

scheduled rate increases; (viii) the requirement that a contingent benefit upon lapse (CBL) be offered for pre-rate stability policies; (ix) an allowance for lower rate increases than necessary under rate stabilization if disclosed and determined to be in best interest of policyholders; (x) a requirement that a rate increase that triggers a CBL be capped at 100% and 0% for policies in force over 20 years; and (xi) language regarding the commission's right to require a hearing on rate increases. These amendments are in accordance with the Bureau's Response to Comments previously filed in this case.

AT RICHMOND, OCTOBER 14, 2014

COMMONWEALTH OF VIRGINIA, ex rel.

STATE CORPORATION COMMISSION

CASE NO. INS-2013-00238

Ex Parte: In the matter of revising the
Rules Governing Long-term Care Insurance

ORDER TO TAKE NOTICE

Section 12.1-13 of the Code of Virginia ("Code") provides that the State Corporation Commission ("Commission") shall have the power to promulgate rules and regulations in the enforcement and administration of all laws within its jurisdiction, and § 38.2-223 of the Code provides that the Commission may issue any rules and regulations necessary or appropriate for the administration and enforcement of Title 38.2 of the Code. In addition, § 38.2-5202 of the Code provides specific authority for the promulgation of regulations pertaining to long-term care insurance.

The rules and regulations issued by the Commission pursuant to § 38.2-223 of the Code are set forth in Title 14 of the Virginia Administrative Code. A copy may also be found at the Commission's website: <http://www.scc.virginia.gov/boi/laws.aspx>.

On November 26, 2012, the Commission entered an Order in which it noted an increase in the number and frequency of long-term care insurance premium rate increase requests. The Commission directed the Bureau of Insurance ("Bureau") to prepare a report that studies premium rate increases associated with long-term care policies.¹ On October 4, 2013, the Bureau filed the requested report ("Report"). Subsequently, the Commission found that it was appropriate to undertake a review of the Report and Chapter 200 of Title 14 of the Virginia Administrative Code, entitled Rules Governing Long-term Care Insurance, 14VAC5-200-10 et seq. ("Rules").² The Commission issued two separate Orders³ to allow interested persons and insurers writing long-term care insurance in Virginia, as well as members of the general public and certain specific individuals, respectively, to comment on the Bureau's Report and propose amendments to the Rules. As a result of those comments, the Bureau filed a Response ("Response") on May 1, 2014, that included a number of specific recommendations for amendments to the Rules. Concurrently, the Commission scheduled a hearing to

receive comments on the Bureau's Response.⁴ The hearing was held on June 19, 2014, at which time public oral comments were received.⁵

Based on the Bureau's Report, written and oral comments, and the Bureau's Response, the Bureau has submitted to the Commission proposed amendments to the Rules, which amend the Rules at 14VAC5-200-30, 14VAC5-200-40, 14VAC5-200-70, 14VAC5-200-75, 14VAC 5-200-77, 14VAC5-200-100, 14VAC5-200-120, 14VAC5-200-150, 14VAC5-200-153, 14VAC5-200-183, and 14VAC5-200-185; repeal the Rules at 14VAC5-200-20; and add new Rules at 14VAC5-200-125, 14VAC5-200-154, and 14VAC5-200-195.

The Bureau submits these proposed amendments to Chapter 200 to address concerns regarding the recent substantial premium rate increases implemented by insurers writing long-term care insurance in Virginia. These amendments, in part, incorporate into Chapter 200 recent revisions to the National Association of Insurance Commissioners' ("NAIC") Model Regulation, as well as the provisions of the NAIC's Model Bulletin of Alternative Filing Requirements for Long-term Care Premium Rate Increases, which applies to rate increases for pre-rate stability policies (those issued prior to October 1, 2003) as well as post-rate stability policies (those issued on or after October 1, 2003) that are currently in effect. These amendments conform to the Bureau's recommendations contained in its Response filed in this case.

NOW THE COMMISSION is of the opinion that the proposed amendments submitted by the Bureau to amend the Rules at 14VAC5-200-30, 14VAC5-200-40, 14VAC5-200-70, 14VAC5-200-75, 14VAC5-200-77, 14VAC5-200-100, 14VAC5-200-120, 14VAC5-200-150, 14VAC5-200-153, 14VAC5-200-183, and 14VAC5-200-185; repeal the Rules at 14VAC5-200-20; and add new Rules at 14VAC5-200-125, 14VAC5-200-154, and 14VAC5-200-195, should be considered for adoption.

Accordingly, IT IS ORDERED THAT:

(1) The proposal to amend the Rules at 14VAC5-200-30, 14VAC5-200-40, 14VAC5-200-70, 14VAC5-200-75, 14VAC5-200-77, 14VAC5-200-100, 14VAC5-200-120, 14VAC5-200-150, 14VAC5-200-153, 14VAC5-200-183, and 14VAC5-200-185; repeal the Rules at 14VAC5-200-20; and add new Rules at 14VAC5-200-125, 14VAC5-200-154, and 14VAC5-200-195, is attached hereto and made a part hereof.

(2) All interested persons who desire to comment in support of or in opposition to, or request a hearing to consider the amendments to Chapter 200 of Title 14, shall file such comments or hearing request on or before December 1, 2014, with Joel H. Peck, Clerk, State Corporation Commission, c/o Document Control Center, P.O. Box 2118, Richmond, Virginia 23218. Interested persons desiring to submit comments electronically may do so by following the instructions at the Commission's

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website: <http://www.scc.virginia.gov/case>. All comments shall refer to Case No. INS-2013-00238.

(3) If no written request for a hearing on the proposal to amend Chapter 200 of Title 14 is received on or before December 1, 2014, the Commission, upon consideration of any comments submitted in support of or in opposition to the proposal, may amend the Rules.

(4) AN ATTESTED COPY hereof, together with a copy of the proposal to amend the Rules, shall be sent by the Clerk of the Commission to the Bureau in care of Deputy Commissioner Althelia P. Battle, who forthwith shall give further notice of the proposal to amend the Rules by mailing a copy of this Order, together with the proposal, to all insurers licensed by the Commission to sell long-term care insurance in Virginia, and to all interested persons.

(5) The Commission's Division of Information Resources forthwith shall cause a copy of this Order, together with the proposal to amend the Rules, to be forwarded to the Virginia Registrar of Regulations for appropriate publication in the Virginia Register of Regulations.

(6) The Commission's Division of Information Resources shall make available this Order and the attached proposed amendments to the Rules on the Commission's website: <http://www.scc.virginia.gov/case>.

(7) The Bureau shall file with the Clerk of the Commission an affidavit of compliance with the notice requirements of Ordering Paragraph (4) above.

(8) This matter is continued.

¹ Commonwealth of Virginia, ex rel., State Corporation Commission, Ex Parte: In the matter of investigating long-term care insurance premium rates, Case No. INS-2012-00282, Doc. Con. Cen. No. 121130186, Order Directing Report (Nov. 26, 2012).

² The Rules can be found at: <http://law.lis.virginia.gov/admincode/title14/agency5/chapter200>.

³ Commonwealth of Virginia, ex rel., State Corporation Commission, Ex Parte: In the matter of revising the Rules Governing Long-term Care Insurance, Case No. INS-2013-00238, Doc. Con. Cen. No. 131130115, Order Initiating Proceeding (Nov. 25, 2013); and Commonwealth of Virginia, ex rel., State Corporation Commission, Ex Parte: In the matter of revising the Rules Governing Long-term Care Insurance, Case No. INS-2013-00238, Doc. Con. Cen. No. 140120003, Amending Order (Jan. 13, 2014).

⁴ Commonwealth of Virginia, ex rel., State Corporation Commission, Ex Parte: In the matter of revising the Rules Governing Long-term Care Insurance, Case No. INS-2013-00238, Doc. Con. Cen. No. 140510027, Order Scheduling Hearing (May 1, 2014).

⁵ A transcript of the hearing can be found at: <http://docket.scc.virginia.gov/vaproduct/main.asp> by using the "Search Cases" feature and searching for Case No. INS-2013-00238.

14VAC5-200-20. ~~Contracts effective prior to April 1, 2003. (Repealed.)~~

~~Except as otherwise specifically provided, each long term care insurance policy delivered or issued for delivery in this Commonwealth prior to April 1, 2003, shall be subject to this chapter as it existed at the time the policy was delivered or issued for delivery.~~

14VAC5-200-30. Applicability and scope.

Except as otherwise specifically provided, this chapter applies to all long-term care ~~insurance~~ insurance policies delivered ~~or~~ issued for delivery, or renewed in this Commonwealth, on or after ~~September 1, 2007~~ (insert effective date of regulation), by insurers, fraternal benefit societies, health services plans, health maintenance organizations, ~~cooperative nonprofit life benefit companies or mutual assessment life, accident and sickness insurers~~ or any other similar organization.

14VAC5-200-40. Definitions.

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

"Applicant" means in the case of an individual long-term care insurance policy, the person who seeks to contract for such benefits, or in the case of a group long-term care insurance policy, the proposed certificateholder.

"Certificate" means any certificate or evidence of coverage issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this Commonwealth.

"Commission" means the Virginia State Corporation Commission.

"Exceptional increase" means only those increases filed by an insurer and identified as exceptional for which the commission determines the need for the premium rate increase is justified (i) due to changes in laws or regulations applicable to long-term care coverage in this Commonwealth, or (ii) due to increased and unexpected utilization that affects the majority of insurers of similar products. Except as provided in 14VAC5-200-153, exceptional increases are subject to the same requirements as other premium rate schedule increases. The commission, in determining that the necessary basis for an exceptional increase exists, shall also determine any potential offsets to higher claims costs.

"Expected loss ratio" means the ratio of the present value of future benefits to the present value of future premiums over the entire period of the contract.

"Group long-term care insurance" means a long-term care insurance policy which complies with § 38.2-3521.1 or § 38.2-3522.1 of the Code of Virginia delivered or issued for delivery in this Commonwealth.

"Incidental," as used in 14VAC5-200-153 J, means that the value of the long-term care benefits provided is less than 10% of the total value of the benefits provided over the life of the policy. These values shall be measured as of the date of issue.

"Insurer" means any insurance company, health services plan, fraternal benefit society, health maintenance organization, ~~cooperative nonprofit life benefit company, or mutual assessment life, accident and sickness insurer~~ or any other similar organization.

"Long-term care insurance" means any insurance policy or rider primarily advertised, marketed, offered or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity, prepaid, or other basis, for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, personal care, mental health or substance abuse services, provided in a setting other than an acute care unit of a hospital. Such term includes group and individual annuities and life insurance policies or riders which provide directly or which supplement long-term care insurance issued by insurers. Such term also includes a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage. With regard to life insurance, this term does not include life insurance policies which accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement, and which provide the option of a lump-sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. Notwithstanding any other provision contained herein, any product advertised, marketed or offered as long-term care insurance shall be subject to the provisions of this chapter. Health maintenance organizations, cooperative nonprofit life benefit companies and mutual assessment life, accident and sickness insurers shall apply to the commission for approval to provide long-term care insurance prior to issuing this type of coverage.

"Policy" means any individual or group policy of insurance, contract, subscriber agreement, certificate, rider or endorsement delivered or issued for delivery in this Commonwealth by an insurer.

"Qualified actuary" means a member ~~in good standing~~ of the American Academy of Actuaries.

"Qualified long-term care insurance contract" or "federally tax-qualified long-term care insurance contract" means:

1. An individual or group insurance contract that meets the requirements of § 7702B(b) of the Internal Revenue Code of 1986 (26 USC § 7702B(b)), as follows:
 - a. The only insurance protection provided under the contract is coverage of qualified long-term care services. A contract shall not fail to satisfy the requirements of this subdivision by reason of payments being made on a per diem or other periodic basis without regard to the

expenses incurred during the period to which the payments relate;

b. The contract does not pay or reimburse expenses incurred for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act (42 USC § 1395 et seq.), or would be so reimbursable but for the application of a deductible or coinsurance amount. The requirements of this subdivision do not apply to expenses that are reimbursable under Title XVIII of the Social Security Act only as a secondary payor. A contract shall not fail to satisfy the requirements of the subdivision by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate;

c. The contract is guaranteed renewable within the meaning of § 7702B(b)(1)(C) of the Internal Revenue Code of 1986;

d. The contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed except as provided in subdivision 1 e of this definition.

e. All refunds of premiums and all policyholder dividends or similar amounts under the contract are to be applied as a reduction in future premiums or to increase future benefits, except that a refund on the event of death of the insured or a complete surrender or cancellation of the contract cannot exceed the aggregate premiums paid under the contract; and

f. The contract meets the consumer protection provisions set forth in § 7702B(g) of the Internal Revenue Code of 1986 and this chapter; or

2. The portion of a life insurance contract that provides long-term care insurance coverage by rider or as part of the contract that satisfies the requirements of § 7702B(b) and (e) of the Internal Revenue Code of 1986.

"Similar policy forms" means all of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered. Certificates of groups as set forth in subsections A and C of § 38.2-3521.1 of the Code of Virginia are not considered similar to certificates or policies otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications. For purposes of determining similar policy forms, long-term care benefit classifications are defined as follows: institutional long-term care benefits only, noninstitutional long-term care benefits only, or comprehensive long-term care benefits.

14VAC5-200-70. Required disclosure provisions.

A. Renewability. Individual long-term care insurance policies shall contain a renewability provision.

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1. The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state that the coverage is guaranteed renewable or noncancellable. This subsection shall not apply to policies that do not contain a renewability provision and under which the right to renew is reserved solely to the policyholder.

2. A long-term care insurance policy or certificate, other than one where the insurer does not have the right to change the premium, shall include a clear and prominent statement in bold type and all capital letters that the premium rates may change be increased.

B. Riders and endorsements. Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy, rider or endorsement.

C. Payment of benefits. A long-term care insurance policy which provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.

D. Limitations. If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Preexisting Condition Limitations."

E. Other limitations or conditions on eligibility for benefits. A long-term care insurance policy or certificate containing post-confinement, post-acute care or recuperative benefits, or any limitations or conditions for eligibility other than those prohibited in § 38.2-5205 A of the Code of Virginia shall set forth a description of such limitations or conditions, including any required number of days of confinement prior to receipt of benefits, in a separate paragraph of the policy or certificate and shall label such paragraph "Limitations or Conditions on Eligibility for Benefits."

F. Disclosure of tax consequences. With regard to life insurance policies which provide an accelerated benefit for long-term care, a disclosure statement is required at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted that receipt

of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents.

G. Benefit triggers. Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and shall be described in the policy or certificate in a separate paragraph and shall be labeled "Eligibility for the Payment of Benefits." Any additional benefit triggers shall also be explained in this section. If these triggers differ for different benefits, explanation of the trigger shall accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too shall be specified.

H. A qualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in 14VAC5-200-200 that the policy is a qualified long-term care insurance contract under § 7702B(b) of the Internal Revenue Code of 1986.

I. A nonqualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in 14VAC5-200-200 that the policy is not intended to be a qualified long-term care insurance contract.

14VAC5-200-75. Required disclosure of rating practices to consumer.

A. Other than policies for which no applicable premium rate or rate schedule increases can be made, insurers shall provide all of the information listed in this subsection to the applicant at the time of application or enrollment, unless the method of application does not allow for delivery at that time. In such a case, an insurer shall provide all of the information listed in this section to the applicant no later than at the time of delivery of the policy or certificate.

1. A statement that the policy may be subject to rate increases in the future;
2. An explanation of potential future premium rate revisions, and the policyholder's or certificateholder's option in the event of a premium rate revision;
3. The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase;
4. A general explanation for applying premium rate or rate schedule adjustments that shall include:
 - a. A description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.); and
 - b. The right to a revised premium rate or rate schedule as provided in subdivision 2 of this subsection if the premium rate or rate schedule is changed;

5. a. Information regarding each premium rate increase on this policy form or similar policy forms over the past 10 years for this Commonwealth or any other state that, at a minimum, identifies:

- (1) The policy forms for which premium rates have been increased;
 - (2) The calendar years when the form was available for purchase; and
 - (3) The amount or percentage of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase, and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics.
- b. The insurer may, in a fair manner, provide additional explanatory information related to the rate increases.
- c. An insurer shall have the right to exclude from the disclosure premium rate increases that only apply to blocks of business acquired from other nonaffiliated insurers or the long-term care policies acquired from other nonaffiliated insurers when those increases occurred prior to the acquisition.
- d. If an acquiring insurer files for a rate increase on a long-term care policy form or a block of policy forms acquired from nonaffiliated insurers 24 months or more following the acquisition of the policy form or the block of policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the nonaffiliated selling company shall include the disclosure of that rate increase in accordance with subdivision 5 a of this subsection.
- e. If the acquiring insurer in subdivision 5 d of this subsection files for a subsequent rate increase, even within the 24-month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from nonaffiliated insurers referenced in subdivision 5 d of this subsection, the acquiring insurer shall make all disclosures required by subdivision 5 of this subsection, including disclosure of the earlier rate increase referenced in subdivision 5 d of this subsection.

B. An applicant shall sign an acknowledgement at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure required under subdivisions A 1 and 5 of this section. If due to the method of application the applicant cannot sign an acknowledgement at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate. The insurer shall maintain copies of the signed acknowledgement for the duration of the policy or certificate.

C. An insurer shall use Forms B and F to comply with the requirements of subsections A and B of this section.

D. An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or

certificateholders, if applicable, at least ~~60~~ 75 days prior to the implementation of the premium rate schedule increase by the insurer. Such notice shall be filed with the commission at the time the premium rate increase is filed. The notice shall include at least the following information required by:

1. All applicable information identified in subsection A of this section when the rate increase is implemented;
2. A clear explanation of any and all options available to the policyholder as alternatives to paying the increased premium amount, including:
 - a. An offer to reduce policy benefits provided by the current coverage consistent with the requirements of 14VAC5-200-183;
 - b. A disclosure stating that all options available to the policyholder may not be of equal value; and
 - c. In the case of a partnership policy, a disclosure that some benefit reduction options may result in a loss in partnership status that may reduce policyholder protections;
3. A clear identification of the driving factors of the premium rate increase; and
4. A statement substantially similar to the following:

The rate increase request was reviewed by the commission and was found to be compliant with applicable Virginia laws and regulations addressing long-term care insurance. All premium rate filings are available for public inspection and may be accessed online through the Virginia Bureau of Insurance's webpage at www.scc.virginia.gov/BOI.

14VAC5-200-77. Initial filing requirements.

- A. This section shall apply to any long-term care policy form filed with the commission on or after (insert effective date of regulation).
- B. An insurer shall provide the information listed in this section to the commission and receive approval of the form prior to making a long-term care insurance form available for sale.

1. A copy of the disclosure documents required in 14VAC5-200-75; and
2. An actuarial certification consisting of at least the following:
 - a. A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;
 - b. An explanation for supporting subdivision 2 a of this subsection, including (i) a description of the margin for moderately adverse experience that is included in the premium rates and (ii) a description of the testing of pricing assumptions that was done to support the conclusion that the filed premium rates are sustainable over the life of the form;

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c. A statement that the policy design and coverage provided have been reviewed and taken into consideration;

d. A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;

e. ~~A complete description of the basis for contract reserves that are anticipated to be held under the form, to include:~~

~~(1) Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held;~~

~~(2) A statement that the assumptions used for reserves contain reasonable margins for adverse experience;~~

~~(3) A statement that the net valuation premium for renewal years does not increase (except for attained age rating); and~~

~~(4) A statement that the difference, in aggregate, between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur. When the difference between the gross premium and the renewal net valuation premiums is not sufficient to cover expected renewal expenses, the description provided should demonstrate the type and level of change in the reserve assumptions that would be necessary for the difference to be sufficient.~~

~~(a) An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship;~~

~~(b) If the gross premiums for certain age groups appear to be inconsistent with this requirement, the commission may request a demonstration based on a standard age distribution; and~~

e. A statement that the premiums contain at least the minimum margin for moderately adverse experience defined in subdivision 2 e (1) of this subsection or the specification of and justification for a lower margin required by subdivision 2 e (2) of this subsection.

(1) A composite margin shall not be less than 10% of lifetime claims.

(2) A composite margin that is less than 10% may be justified in uncommon circumstances. The proposed amount, full justification of the proposed amount, and methods to monitor developing experience that would be the basis for withdrawal of approval for such lower margins shall be submitted.

(3) A composite margin lower than otherwise considered appropriate for the stand-alone long-term care policy may be justified for long-term care benefits provided through a life policy or an annuity contract. Such lower

composite margin, if utilized, shall be justified by appropriate actuarial demonstration addressing margins and volatility when considering the entirety of the product.

(4) A greater margin may be appropriate in circumstances where the company has less credible experience to support its assumptions used to determine the premium rates.

f. (1) A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or

(2) A comparison of the premium rate schedules for similar policy forms that are currently available from the insurer with an explanation of the differences. It is not expected that the insurer will need to provide a comparison of every age and set of benefits, period of payment or elimination period. A broad range of expected combinations is to be provided in a manner designed to provide a fair presentation for review by the commission.

g. A statement that reserve requirements have been reviewed and considered. Support for this statement shall include: (i) sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held; and (ii) a statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur. An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship.

3. An actuarial memorandum ~~that includes~~ prepared, dated, and signed by a qualified actuary shall be included and shall address and support each specific item required as part of the actuarial certification and provide at least the following information:

a. A description of the basis on which the long-term care insurance premium rates were determined;

b. A description of the basis for the reserves;

c. A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

d. A description and a table of each actuarial assumption used. For expenses, an insurer must include percentage of premium dollars per policy and dollars per unit of benefits, if any;

e. A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

- f. The estimated average annual premium per policy and the average issue age; ~~and~~
- g. A statement that includes a description of the types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs;
- h. An explanation of the review performed by the actuary prior to making the statements in subdivisions B 2 c and d of this section;
- i. A complete description of pricing assumptions;
- j. Sources and levels of margins incorporated into the gross premiums that are the basis for the statement in subdivision B 2 a of this section of the actuarial certification and an explanation of the analysis and testing performed in determining the sufficiency of the margins. Deviations in margins between ages, sexes, plans, or states shall be clearly described. Deviations in margins required to be described are other than those produced utilizing generally accepted actuarial methods for smoothing and interpolating gross premium scales;
- k. A demonstration that the gross premiums include the minimum composite margin specified in subdivision B 2 e of this section; and
- l. The anticipated loss ratio and a description of how it was calculated.

14VAC5-200-100. Requirement to offer inflation protection.

A. No insurer may offer a long-term care insurance policy unless the insurer also offers to the policyholder in addition to any other inflation protection offers the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

- 1. Increases benefit levels annually, in a manner so that the increases are compounded annually, at a rate not less than 5.0%;
- 2. Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status; so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least 5.0% for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or

3. Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

B. Where the policy is issued to a group, the required offer in subsection A ~~above of this section~~ shall be made to each proposed certificateholder; except if the policy is issued to a continuing care retirement community the offering shall be made to the group policyholder.

C. The offer in ~~Subsection above~~ subsection A of this section shall not be required of life insurance policies or riders containing accelerated long-term care benefits.

D. Insurers shall include the following information in or with the outline of coverage:

- 1. A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a ~~20-year~~ 20-year period.
- 2. Any expected premium increases or additional premiums to pay for automatic or optional benefit increases. If premium increases or additional premiums will be based on the attained age of the applicant at the time of the increase, the insurer shall also disclose the magnitude of the potential premiums the applicant would need to pay at ages 75 and 85 for benefit increases. An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure.

14VAC5-200-120. Reporting requirements.

A. Every insurer shall maintain records for each agent of that agent's amount of replacement sales as a percent of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent's total annual sales.

B. Every insurer shall report annually by June 30 the 10% of its agents with the greatest percentages of lapses and replacements as measured by subsection A of this section (Form G).

C. Reported replacement and lapse rates do not alone constitute a violation of the insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance.

D. Every insurer shall report annually by June 30 the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year (Form G).

E. Every insurer shall report annually by June 30 the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year (Form G).

F. Every insurer shall report annually by June 30, for qualified long-term care insurance contracts, the number of

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claims denied for each class of business, expressed as a percentage of claims denied (Form E).

G. For purposes of this section:

1. Subject to subdivision 2 of this subsection, "claim" means a request for payment of benefits under an in-force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met;
2. "Denied" means the insurer refuses to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition;
3. "Policy" means only long-term care insurance; and
4. "Report" means on a statewide basis.

H. Reports required under this section shall be based on the previous calendar year data and filed with the commission.

14VAC5-200-125. Annual rate reports.

A. Every insurer shall report to the commission annually by June 30 premium rates for all long-term care insurance policies. The commission shall post this report to the Bureau of Insurance's webpage. The rate report shall include:

1. For policies issued on or after October 1, 2003, an actuarial certification prepared, dated, and signed by a qualified actuary that provides at least the following information:

a. A statement of the sufficiency of the current premium rate schedule including:

(1) For policies currently marketed:

(a) The premium rate schedule continues to be sufficient to cover anticipated costs under moderately adverse experience, consistent with the margins as defined in the original rate filing or any subsequent rate filing, and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated; or

(b) If the statement in subdivision 1 a (1) (a) of this subsection cannot be made, a statement that margins for moderately adverse experience, consistent with the margins as defined in the original rate filing or any subsequent rate filing, may no longer be sufficient. In this situation, the insurer shall submit to the commission within 60 days of the date of the actuarial certification a plan of action, including a timeframe, for the reestablishment of adequate margins for moderately adverse experience so that the ultimate premium rate schedule would be reasonably expected to be sustainable over the future life of the form with no future premium increases anticipated. Failure to submit a plan of action to the commission within 60 days or to comply with the timeframe stated in the plan of action constitutes grounds for withdrawal or modification of approval of the form for future sales.

(2) For policies that are no longer marketed:

(a) A statement that the premium rate schedule continues to be sufficient to cover anticipated costs under best estimate assumptions; or

(b) A statement that the premium rate schedule may no longer be sufficient. The insurer shall submit to the commission within 60 days of the date of the actuarial certification a plan of action, including a timeframe for the reestablishment of adequate margins for moderately adverse experience.

b. A description of the review performed that led to the statement.

c. At least once every three years, an actuarial memorandum dated and signed by a qualified actuary that supports the actuarial certification and provides at least the following information:

(1) A detailed explanation of the data sources and review performed by the actuary prior to making the statement in subdivision 1 a (1) of this subsection;

(2) A complete description of experience assumptions and their relationship to the initial pricing assumptions;

(3) A description of the credibility of the experience data; and

(4) An explanation of the analysis and testing performed in determining the current presence of margins.

2. For policies issued prior to October 1, 2003, the report shall include a statement signed by a qualified actuary that a complete analysis and review of the premium rates was conducted, a description of the analysis, the date on which the analysis was completed, and any rate action found to be necessary as a result of the analysis.

B. Reports required in this section shall be based on the previous calendar year data and filed with the commission no later than June 30. The commission may request any additional information that will support the information required in this section.

14VAC5-200-150. ~~Loss ratio~~ Premium rate increases for policies issued before October 1, 2003.

A. This section ~~shall apply~~ applies to all any premium rate increase filed with the commission on or after (insert effective date of regulation) for any long-term care insurance policies or certificates except those covered under 14VAC5-200-77 and 14VAC5-200-153 policy issued in this Commonwealth before October 1, 2003.

B. Benefits under individual long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least 60% calculated in a manner which provides for adequate reserving of the long-term care insurance risk the greater of 60% or the lifetime loss ratio used in the original pricing applied to the current rate schedule plus: (i) 80% applied to any premium rate

increase for individual policy forms or (ii) 75% applied to any premium rate increase on group policy forms.

In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:

1. Statistical credibility of incurred claims experience and earned premiums;
2. The period for which rates are computed to provide coverage;
3. Experienced and projected trends;
4. Concentration of experience within early policy duration;
5. Expected claim fluctuation;
6. Experience refunds, adjustments or dividends;
7. Renewability features;
8. All appropriate expense factors;
9. Interest;
10. Experimental nature of the coverage;
11. Policy reserves;
12. Mix of business by risk classification; and
13. Product features such as long elimination periods, high deductibles and high maximum limits.

Demonstrations of loss ratios shall be made in compliance with the Rules Governing the Filing of Rates for Individual and Certain Group Accident and Sickness Insurance Policy Forms, ~~Chapter 130~~ (14VAC5-130) of this title.

C. Any insurer may request a series of scheduled rate increases that are actuarially equivalent to a single amount requested over the lifetime of the policy. The entire series may be approved at one time as part of the current rate increase filing.

D. As a condition of approval of a rate increase for a block of business for which the contingent benefit upon lapse is not otherwise required, a contingent benefit upon lapse provision will be required in accordance with 14VAC5-200-185 D. If the rate increase is approved in a series of scheduled rate increases and the sum of all scheduled rate increases will trigger the offering of a contingent benefit upon lapse, the insurer shall be required to include contingent benefit upon lapse at the time of each scheduled increase.

E. All submissions shall include information required by 14VAC5-200-75.

E. Subsection B of this section shall not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following provisions:

1. The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed

interest rate for cash value accumulations without long-term care set forth in the policy;

2. The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of Chapter 32 (§ 38.2-3200 et seq.) of Title 38.2 of the Code of Virginia;

3. If an application for a long-term care insurance contract or certificate is approved, the issuer shall deliver the contract or certificate of insurance to the applicant no later than 30 days after the date of approval;

4. At the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy that provides long-term care benefits within the policy or by rider. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request, but regardless of request shall make delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, the summary shall also include:

a. An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;

b. An illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits, if any, for each covered person;

c. Any exclusions, reductions and limitations on benefits of long-term care;

d. A statement that any long-term care inflation protection option required by 14VAC5-200-100 is not available under this policy;

e. If applicable to the policy type, the summary shall also include:

(1) A disclosure of the effects of exercising other rights under the policy;

(2) A disclosure of guarantees related to long-term care costs of insurance charges; and

(3) Current and projected maximum lifetime benefits; and

f. The provisions of the policy summary listed above may be incorporated into a basic illustration or into the life insurance policy summary;

5. Any time a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status, a monthly report shall be provided to the policyholder. The report shall include:

a. Any long-term care benefits paid out during the month;

b. An explanation of any changes in the policy; (e.g., death benefits or cash values;) due to long-term care benefits being paid out; and

c. The amount of long-term care benefits existing or remaining;

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6. Any policy illustration that meets the applicable requirements of ~~14VAC5-40~~ 14VAC5-41; and

7. An actuarial memorandum is filed with the Bureau of Insurance that includes:

- a. A description of the basis on which the long-term care rates were determined;
- b. A description of the basis for the reserves;
- c. A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;
- d. A description and a table of each actuarial assumption used. For expenses, an insurer must include percentage of premium dollars per policy and dollars per unit of benefits, if any;
- e. A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;
- f. The estimated average annual premium per policy and the average issue age;
- g. A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and
- h. A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status.

14VAC5-200-153. Premium rate schedule increases for policies issued on or after October 1, 2003, but prior to (insert effective date of regulation).

A. This section applies to any premium rate increase filed with the commission on or after (insert effective date of regulation) for any long-term care insurance policy or certificate issued in this Commonwealth on or after October 1, 2003, but prior to (insert effective date of regulation).

B. An insurer shall request the commission's approval of a pending premium rate schedule increase, including an exceptional increase, prior to the notice to the policyholders and shall include:

1. Information required by 14VAC5-200-75;
2. Certification by a qualified actuary that:
 - a. If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated; and

b. The premium rate filing is in compliance with the provisions of this section;

3. An actuarial memorandum justifying the rate schedule change request that includes:

a. Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale;

(1) Annual values for the five years preceding and the three years following the valuation date shall be provided separately;

(2) The projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;

(3) The projections shall demonstrate compliance with subsection C of this section; and

(4) For exceptional increases,

(a) The projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and

(b) In the event the commission determines as provided in the definition of exceptional increase in 14VAC5-200-40 that offsets may exist, the insurer shall use appropriate net projected experience;

b. Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;

c. Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary;

d. A statement that policy design, underwriting, and claims adjudication practices have been taken into consideration; ~~and~~

e. In the event that it is necessary to maintain consistent premium rates for new policies and policies receiving a rate increase, the insurer will need to file composite rates reflecting projections of new policies; and

f. A demonstration that actual and projected costs exceed costs anticipated at the time of initial pricing under moderately adverse experience and that the composite margin is projected to be exhausted;

4. A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the commission; and

5. Sufficient information for review and approval of the premium rate schedule increase by the commission.

An insurer may request a series of scheduled rate increases that are actuarially equivalent to a single amount requested over the lifetime of the policy. The entire series may be approved at one time as part of the current rate increase filing. The insurer shall be required to include contingent benefit upon lapse at the time of each scheduled increase.

The insurer may request a premium rate schedule increase less than what is required under this section and the commission may approve such premium rate schedule increase, without submission of the certification in subdivision 2 a of this subsection, if the actuarial memorandum discloses the premium rate schedule increase necessary to make such certification required, the premium rate schedule increase filing satisfies all other requirements of this section, and is, in the opinion of the commission, in the best interest of policyholders.

C. All premium rate schedule increases shall be determined in accordance with the following requirements:

1. Exceptional increases shall provide that 70% of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;
2. Premium rate schedule increases shall be calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:
 - a. The accumulated value of the initial earned premium times 58%;
 - b. ~~Eighty five percent~~ 85% of the accumulated value of prior premium rate schedule increases on an earned basis;
 - c. The present value of future projected initial earned premiums times 58%; and
 - d. ~~Eighty five percent~~ 85% of the present value of future projected premiums not in subdivision 2 c of this subsection on an earned basis;
3. In the event that a policy form has both exceptional and other increases, the values in subdivisions 2 b and d of this subsection will also include 70% for exceptional rate increase amounts; and
4. All present and accumulated values used to determine rate increases shall use the greater of the maximum valuation interest rate for contract reserves as specified in § 38.2-3132 of the Code of Virginia or interest at a rate consistent with that assumed in the original determination of premiums. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

D. For each rate increase that is implemented, the insurer shall file for approval by the commission updated projections, as defined in subdivision B 3 a of this section, annually for the next three years and include a comparison of actual results

to projected values. The commission may extend the period to greater than three years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in subsection K of this section, the projections required by subdivision B 3 a of this section shall be provided to the policyholder in lieu of filing with the commission.

E. If any increased premium rate in the revised premium rate schedule is greater than 200% of the comparable rate in the initial premium schedule, the premiums exceeding 200% shall be clearly identified and lifetime projections, as defined in subdivision B 3 a of this section, shall be filed for approval by the commission every five years following the end of the required period in subsection D of this section. For group insurance policies that meet the conditions in subsection K of this section, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commission.

F. 1. If the commission has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in subsection C of this section, the commission may require the insurer to implement any of the following:

- a. Premium rate schedule adjustments; or
- b. Other measures to reduce the difference between the projected and actual experience.

It is to be expected that the actual experience will not exactly match the insurer's projections. During the period that projections are monitored as described in subsections D and E of this section, the commission should determine that there is not an adequate match if the differences in earned premiums and incurred claims are not in the same direction (both actual values higher or lower than projections) or the difference as a percentage of the projected is not of the same order.

2. In determining whether the actual experience adequately matches the projected experience, consideration should be given to subdivision B 3 e of this section, if applicable.

G. If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file:

1. A plan, subject to commission approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the commission may impose the condition in subsection H of this section; and

2. The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been

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calculated according to subsection C of this section had the greater of the original anticipated lifetime loss ratio or 58% been used in the calculations described in subdivisions C 2 a and c of this section.

H. 1. For a rate increase filing that meets the following criteria, the commission shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the 12 months following each increase to determine if significant adverse lapsation has occurred or is anticipated:

- a. The rate increase is not the first rate increase requested for the specific policy form or forms;
- b. The rate increase is not an exceptional increase; and
- c. The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

2. In the event significant adverse lapsation has occurred, is anticipated in the filing or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the commission may determine that a rate spiral exists. Following the determination that a rate spiral exists, the commission may require the insurer to offer, without underwriting, to all in-force insureds subject to the rate increase the option to replace existing coverage with any other long-term care insurance product being offered by the insurer or its affiliates.

a. The offer shall:

- (1) Be subject to the approval of the commission;
- (2) Be based on actuarially sound principles, but not be based on attained age; and
- (3) Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.

b. The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of:

- (1) The maximum rate increase determined based on the combined experience; or
- (2) The maximum rate increase determined based only on the experience of the insureds originally issued the form plus 10%.

I. If the commission determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the commission may, in addition to the provisions of subsection H of this section, prohibit the insurer from either of the following:

1. Filing and marketing comparable coverage for a period of up to five years; or

2. Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

J. Subsections A through I of this section shall not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in 14VAC5-200-40, if the policy complies with all of the following provisions:

1. The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

2. The portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in any of the following:

a. Sections 38.2-3200 through 38.2-3218 of the Code of Virginia, ~~and, or~~

b. Sections 38.2-3219 through 38.2-3229 of the Code of Virginia;

3. The policy meets the disclosure requirements of §§ 38.2-5207.1 and 38.2-5207.2 of the Code of Virginia;

4. The portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements as applicable in ~~the following:~~

~~a. Policy illustrations as required by 14VAC5-40; 14VAC5-20 and~~

~~b. Disclosure requirements in 14VAC5-40 14VAC5-41;~~

5. An actuarial memorandum is filed with the commission that includes:

a. A description of the basis on which the long-term care rates were determined;

b. A description of the basis for the reserves;

c. A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

d. A description and a table of each actuarial assumption used. For expenses, an insurer shall include percent of premium dollars per policy and dollars per unit of benefits, if any;

e. A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

f. The estimated average annual premium per policy and the average issue age;

g. A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group

policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

h. A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

K. Subsections F and H of this section shall not apply to group insurance policies as defined in subsections A and C of § 38.2-3521.1 of the Code of Virginia where:

1. The policies insure 250 or more persons and the policyholder has 5,000 or more eligible employees of a single employer; or

2. The policyholder, and not the certificateholders, pays a material portion of the premium, which shall not be less than 20% of the total premium for the group in the calendar year prior to the year a rate increase is filed.

14VAC5-200-154. Premium rate increases for policies issued after (insert effective date of regulation).

A. An insurer shall request the commission's approval of a pending premium rate schedule increase, including an exceptional increase, prior to the notice to the policyholders and shall include:

1. Information required by 14VAC5-200-75;

2. Certification by a qualified actuary that:

a. If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated; and

b. The premium rate filing is in compliance with the provisions of this section;

3. An actuarial memorandum justifying the rate schedule change request that includes:

a. Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale;

(1) Annual values for the five years preceding and the three years following the valuation date shall be provided separately;

(2) The projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;

(3) The projections shall demonstrate compliance with subsection B of this section; and

(4) For exceptional increases:

(a) The projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and

(b) In the event the commission determines as provided in the definition of exceptional increase in 14VAC5-200-40 that offsets may exist, the insurer shall use appropriate net projected experience;

b. Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;

c. Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary;

d. A statement that policy design, underwriting, and claims adjudication practices have been taken into consideration;

e. In the event that it is necessary to maintain consistent premium rates for new policies and policies receiving a rate increase, the insurer will need to file composite rates reflecting projections of new policies; and

f. A demonstration that actual and projected costs exceed costs anticipated at the time of initial pricing under moderately adverse experience and that the composite margin is projected to be exhausted;

4. A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the commission; and

5. Sufficient information for review and approval of the premium rate schedule increase by the commission.

An insurer may request a series of scheduled rate increases that are actuarially equivalent to a single amount requested over the lifetime of the policy. The entire series may be approved at one time as part of the current rate increase filing. The insurer shall be required to include contingent benefit upon lapse at the time of each scheduled increase.

The insurer may request a premium rate schedule increase less than what is required under this section and the commission may approve such premium rate schedule increase, without submission of the certification in subdivision 2 a of this subsection, if the actuarial memorandum discloses the premium rate schedule increase necessary to make such certification required, the premium rate schedule increase filing satisfies all other requirements of this section, and is, in the opinion of the commission, in the best interest of policyholders.

B. All premium rate schedule increases shall be determined in accordance with the following requirements:

1. Exceptional increases shall provide that 70% of the present value of projected additional premiums from the

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exceptional increase will be returned to policyholders in benefits;

2. Premium rate schedule increases shall be calculated such that the sum of the lesser of (i) the accumulated value of actual incurred claims, without the inclusion of active life reserves, or (ii) the accumulated value of historic expected claims without the inclusion of active life reserves, plus the present value of the future expected incurred claims, projected without the inclusion of actual life reserves, will not be less than the sum of the following:

a. The accumulated value of the initial earned premium times the greater of (i) 58% and (ii) the lifetime loss ratio consistent with the original filing including margins for moderately adverse experience;

b. 85% of the accumulated value of prior premium rate schedule increases on an earned basis;

c. The present value of future projected initial earned premiums times the greater of (i) 58% and (ii) the lifetime loss ratio consistent with the original filing including margins for moderately adverse experience; and

d. 85% of the present value of future projected premiums not in subdivision 2 c of this subsection on an earned basis.

3. Expected claims shall be calculated based on the original filing assumptions assumed until new assumptions are filed as part of a rate increase. New assumptions shall be used for all periods beyond each requested effective date of a rate increase. Expected claims are calculated for each calendar year based on the in-force policies at the beginning of the calendar year. Expected claims shall include margins for moderately adverse experience; either amounts included in the claims that were used to determine the lifetime loss ratio consistent with the original filing or as modified in any rate increase filing;

4. In the event that a policy form has both exceptional and other increases, the values in subdivisions 2 b and d of this subsection will also include 70% for exceptional rate increase amounts; and

5. All present and accumulated values used to determine rate increases, including the lifetime loss ratio consistent with the original filing reflecting margins for moderately adverse experience, shall use the greater of the maximum valuation interest rate for contract reserves as specified in 14VAC5-320 or interest at a rate consistent with that assumed in the original determination of premiums. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

C. For each rate increase that is implemented, the insurer shall file for approval by the commission updated projections, as defined in subdivision A 3 a of this section, annually for the next three years and include a comparison of actual results to projected values. The commission may extend the period to

greater than three years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in subsection J of this section, the projections required by subdivision A 3 a of this section shall be provided to the policyholder in lieu of filing with the commission.

D. If any increased premium rate in the revised premium rate schedule is greater than 200% of the comparable rate in the initial premium schedule, the premiums exceeding 200% shall be clearly identified and lifetime projections, as defined in subdivision A 3 a of this section, shall be filed for approval by the commission every five years following the end of the required period in subsection C of this section. For group insurance policies that meet the conditions in subsection J of this section, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commission.

E. 1. If the commission has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in subsection B of this section, the commission may require the insurer to implement any of the following:

a. Premium rate schedule adjustments; or

b. Other measures to reduce the difference between the projected and actual experience.

It is to be expected that the actual experience will not exactly match the insurer's projections. During the period that projections are monitored as described in subsections C and D of this section, the commission may determine that there is not an adequate match if the differences in earned premiums and incurred claims are not in the same direction (both actual values higher or lower than projections) or the difference as a percentage of the projected is not of the same order.

2. In determining whether the actual experience adequately matches the projected experience, consideration should be given to subdivision A 3 e of this section, if applicable.

F. If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file a plan, subject to commission approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the commission may impose the condition in subsection G of this section.

G. 1. For a rate increase filing that meets the following criteria, the commission shall review, for all policies included in the filing, the projected lapse rates and past lapse rates

during the 12 months following each increase to determine if significant adverse lapsation has occurred or is anticipated:

- a. The rate increase is not the first rate increase requested for the specific policy form or forms;
- b. The rate increase is not an exceptional increase; and
- c. The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

2. In the event significant adverse lapsation has occurred, is anticipated in the filing, or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the commission may determine that a rate spiral exists. Following the determination that a rate spiral exists, the commission may require the insurer to offer, without underwriting, to all in-force insureds subject to the rate increase the option to replace existing coverage with any other long-term care insurance product being offered by the insurer or its affiliates.

a. The offer shall:

(1) Be subject to the approval of the commission;

(2) Be based on actuarially sound principles, but not be based on attained age; and

(3) Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.

b. The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of:

(1) The maximum rate increase determined based on the combined experience; or

(2) The maximum rate increase determined based only on the experience of the insureds originally issued the form plus 10%.

H. If the commission determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the commission may, in addition to the provisions of subsection G of this section, prohibit the insurer from either of the following:

1. Filing and marketing comparable coverage for a period of up to five years; or

2. Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

I. Subsections A through H of this section shall not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in 14VAC5-200-40, if the policy complies with all of the following provisions:

1. The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

2. The portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in any of the following:

a. Sections 38.2-3200 through 38.2-3218 of the Code of Virginia; or

b. Sections 38.2-3219 through 38.2-3229 of the Code of Virginia;

3. The policy meets the disclosure requirements of §§ 38.2-5207.1 and 38.2-5207.2 of the Code of Virginia;

4. The portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements as applicable in 14VAC5-20 and 14VAC5-41;

5. An actuarial memorandum is filed with the commission that includes:

a. A description of the basis on which the long-term care rates were determined;

b. A description of the basis for the reserves;

c. A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

d. A description and a table of each actuarial assumption used. For expenses, an insurer shall include percent of premium dollars per policy and dollars per unit of benefits, if any;

e. A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

f. The estimated average annual premium per policy and the average issue age;

g. A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

h. A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

J. Subsections E and G of this section shall not apply to group insurance policies as defined in subsections A and C of § 38.2-3521.1 of the Code of Virginia where:

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1. The policies insure 250 or more persons and the policyholder has 5,000 or more eligible employees of a single employer; or

2. The policyholder, and not the certificateholders, pays a material portion of the premium, which shall not be less than 20% of the total premium for the group in the calendar year prior to the year a rate increase is filed.

14VAC5-200-183. Right to reduce coverage and lower premiums.

A. 1. Every long-term care insurance policy and certificate shall include a provision that allows the policyholder or certificateholder to reduce coverage and lower the policy or certificate premium in at least one of the following ways:

- a. Reducing the maximum benefit; or
- b. Reducing the daily, weekly or monthly benefit amount.

2. The insurer may also offer other reduction options that are consistent with the policy or certificate design or the carrier's administrative processes.

3. In the event the reduction in coverage involves the reduction or elimination of the inflation protection provision, the insurer shall allow the policyholder to continue the benefit amount in effect at the time of the reduction.

B. The provision shall include a description of the ~~ways in which coverage may be reduced and the~~ process for requesting and implementing a reduction in coverage.

~~C. The age to determine the premium for the reduced coverage shall be based on the age used to determine the premiums for the coverage currently in force~~ The premium for the reduced coverage shall be:

1. Based on the same age and underwriting class used to determine the premium for the coverage currently in force; and
2. Consistent with the approved rate table.

D. The insurer may limit any reduction in coverage to plans or options available for that policy form and to those for which benefits will be available after consideration of claims paid or payable.

E. If a policy or certificate is about to lapse, the insurer shall provide a written reminder to the policyholder or certificateholder of his right to reduce coverage and premiums in the notice required by 14VAC5-200-65 A 3.

F. This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

14VAC5-200-185. Nonforfeiture benefit requirement.

A. This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

B. To comply with the requirement to offer a nonforfeiture benefit pursuant to the provisions of § 38.2-5210 of the Code of Virginia:

1. A policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefit described in subsection E of this section; and

2. The offer shall be in writing if the nonforfeiture benefit is not otherwise described in the Outline of Coverage or other materials given to the prospective policyholder.

When a group long-term care insurance policy is issued, the offer required in § 38.2-5210 of the Code of Virginia shall be made to the group policyholder. However, if the policy is issued as group long-term care insurance as defined in § 38.2-3522.1 of the Code of Virginia other than to a continuing care retirement community or other similar entity, the offer shall be made to each proposed certificateholder.

C. If the offer required to be made under § 38.2-5210 of the Code of Virginia is rejected, the insurer shall provide the contingent benefit upon lapse described in this section. Even if this offer is accepted for a policy with a fixed or limited premium paying period, the contingent benefit upon lapse in subdivision D 4 of this section shall still apply.

D. 1. After rejection of the offer required under § 38.2-5210 of the Code of Virginia, for individual and group policies without nonforfeiture benefits, the insurer shall provide a contingent benefit upon lapse.

2. In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificateholder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.

3. A contingent benefit ~~on~~ upon lapse shall be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below based on the insured's issue age, and the policy or certificate lapses within 120 days of the due date of the premium so increased. Unless otherwise required, policyholders shall be notified at least ~~60~~ 75 days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
29 <u>54</u> and under	200% <u>100%</u>
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%

62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

4. A contingent benefit on lapse shall also be triggered for policies with a fixed or limited premium paying period every time an insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below based on the insured's issue age, the policy or certificate lapses within 120 days of the due date of the premium so increased, and the ratio in subdivision 6 b of this subsection is 40% or more. Unless otherwise required, policyholders shall be notified at least ~~60~~ 75 days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
Under 65	50%
65-80	30%
Over 80	10%

This provision shall be in addition to the contingent benefit provided by subdivision 3 of this subsection, and where both are triggered, the benefit provided shall be at the option of the insured.

5. On or before the effective date of a substantial premium increase as defined in subdivision 3 of this subsection, the insurer shall:

- a. Offer to reduce policy benefits provided by the current coverage ~~without the requirement of additional underwriting~~ consistent with 14VAC5-200-183 so that required premium payments are not increased;
- b. Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of subsection E of this section. This option may be elected at any time during the 120-day period referenced in subdivision 3 of this subsection; and
- c. Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in subdivision 3 of this subsection shall be deemed to be the election of the offer to convert in subdivision 5 b of this subsection unless the automatic option in subdivision 6 c of this subsection applies.

6. On or before the effective date of a substantial premium increase as defined in subdivision 4 of this subsection, the insurer shall:

- a. Offer to reduce policy benefits provided by the current coverage ~~without the requirement of additional underwriting~~ consistent with the requirements of 14VAC5-200-183 so that required premium payments are not increased;
- b. Offer to convert the coverage to a paid-up status where the amount payable for each benefit is 90% of the amount payable in effect immediately prior to lapse times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period. This option may be elected at any time during the 120-day period referenced in subdivision 4 of this subsection; and
- c. Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in subdivision 4 of this subsection shall be deemed to be the election of the offer to convert in subdivision 6 b of this subsection if the ratio is 40% or more.

7. In the event the policy was issued at least 20 years prior to the effective date of the premium rate increase, a value of 0% shall be used in place of all values in the tables in subdivision 3 or 4 of this subsection.

E. Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse in accordance with subdivision D 3 but not subdivision D 4 of this section, are described in this subsection:

- 1. For purposes of this subsection, attained age rating is defined as a schedule of premiums starting from the issue date which increases age at least 1.0% per year prior to age 50, and at least 3.0% per year ~~beyond~~ at age 50 and beyond.

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2. For purposes of this subsection, the nonforfeiture benefit shall be of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in subdivision 3 of this subsection.

3. The standard nonforfeiture credit will be equal to 100% of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than 30 times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of subsection F of this section.

4. a. The nonforfeiture benefit shall begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse shall be effective during the first three years as well as thereafter.

b. Notwithstanding subdivision 4 a of this subsection, except that for a policy or certificate with a contingent benefit upon lapse or a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of: (i) the end of the tenth year following the policy or certificate issue date; or (ii) the end of the second year following the date the policy or certificate is no longer subject to attained age rating.

5. Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

F. All benefits paid by the insurer while the policy or certificate is in premium paying status and in the ~~paid-up~~ paid-up status will not exceed the maximum benefits which would be payable if the policy or certificate had remained in premium paying status.

G. There shall be no difference in the minimum nonforfeiture benefits as required under this section for group and individual policies.

H. Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse shall be subject to the loss ratio requirements of 14VAC5-200-150 ~~or~~, 14VAC5-200-153, or 14VAC5-200-154, whichever is applicable, treating the policy as a whole.

I. To determine whether contingent nonforfeiture upon lapse provisions are triggered under subdivision D 3 or D 4 of this section, a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the

insured when the policy was first purchased from the original insurer.

J. A nonforfeiture benefit for qualified long-term care insurance contracts that are level premium contracts shall be offered that meets the following requirements:

1. The nonforfeiture provision shall be appropriately captioned;

2. The nonforfeiture provision shall provide a benefit available in the event of a default in the payment of any premiums and shall state that the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency and interest as reflected in changes in rates for premium paying contracts approved by the commission for the same contract form; and

3. The nonforfeiture provision shall provide at least one of the following:

a. Reduced paid-up insurance;

b. Extended term insurance;

c. Shortened benefit period; or

d. Other similar offerings approved by the commission.

14VAC5-200-195. Rate increase hearings.

The commission may, at its sole discretion and as a condition of approval, conduct a public hearing or order an insurer to present information concerning its premium rate increase submission before the commission if it determines that a hearing or presentation is in the public interest. One consideration for a hearing may be the percentage or level of premium rate increase requested.

VA.R. Doc. No. R15-4149; Filed October 14, 2014, 11:20 a.m.

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARD OF NURSING

Fast-Track Regulation

Title of Regulation: **18VAC90-21. Medication Administration Training and Immunization Protocol (amending 18VAC90-21-30).**

Statutory Authority: §§ 54.1-2400 and 54.1-3005 of the Code of Virginia.

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: December 3, 2014.

Effective Date: December 18, 2014.

Agency Contact: Jay P. Douglas, R.N., Executive Director, Board of Nursing, 9960 Mayland Drive, Suite 300,

Richmond, VA 23233-1463, telephone (804) 367-4515, FAX (804) 527-4455, or email jay.douglas@dhp.virginia.gov.

Basis: Section 54.1-2400 of the Code of Virginia establishes the general powers and duties of health regulatory boards including the responsibility to promulgate regulations.

The second enactment clause of Chapter 183 of the 2013 Acts of the Assembly mandates that the Board of Nursing promulgate regulations to implement the provisions of Chapter 183 relating to medication administration training for the administration of epinephrine and glucagon.

Purpose: The purpose of the amendments is to include training in the signs of hypoglycemia and the administration of glucagon to the module on training in the administration of insulin. The 32-hour training program set out in 18VAC30-21-30 is used for training unlicensed persons to administer medications in certain facilities as prescribed in § 54.1-3408 L of the Code of Virginia. If a person is authorized to assist with the administration of insulin, he should also be trained in the administration of a rescue dose of glucagon. Since Chapter 183 provides that employees of or persons providing services pursuant to a contract with a provider licensed by the Department of Behavioral Health and Developmental Services (DBHDS) may administer insulin, glucagon, and epinephrine pursuant to a written order issued by a prescriber in certain circumstances, training in administration of those drugs is essential to protect public health and safety for persons receiving services in a DBHDS facility.

Rationale for Using Fast-Track Process: The amendments are mandated by and necessary to implement the statute. The amendments are not controversial, and the curriculum already exists for such training.

Substance: This action will amend the 32-hour medication administration program to add "signs of severe hypoglycemia and administration of glucagon" to the insulin module. It will also add a provision to the curriculum for the purpose of "Facilitating client self-administration or assisting with the administration of auto-injectable epinephrine pursuant to an order issued by the prescriber for a specific client in a facility licensed by the Department of Behavioral Health and Developmental Services under provisions of subsection D of § 54.1-3408 of the Code of Virginia."

Issues: The primary advantage is to those persons who are receiving services in a DBHDS licensed facility and who may have diabetes or severe allergies. There are no advantages or disadvantages to the general public.

There are no advantages or disadvantages to the Department of Health Professions, but there are advantages to DBHDS, which will be able to train and utilize unlicensed persons to administer insulin, glucagon, and auto-injectable epinephrine.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. Pursuant to Chapter 183 of the 2013 Acts of the Assembly,

the Board of Nursing (Board) proposes to add training in epinephrine and glucagon administration to the curriculum for the classroom instruction provided to certain individuals

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

Estimated Economic Impact. Pursuant to Chapter 183 of the 2013 Acts of the Assembly, the proposed regulations add training in epinephrine and glucagon administration to the curriculum for the classroom instruction established by the Board for the employees of or persons providing services based on a written contract with a provider licensed by the Department of Behavioral Health and Developmental Services (DBHDS).

The Board does not plan to increase the length of the required classroom instruction and does not anticipate any reduction in the quantity and quality of other topics that need to be covered by the training. Thus, no significant economic costs are expected from the proposed expansion of the training curriculum. However, the proposed new training is expected to improve chances of survival if and when epinephrine or glucagon has to be administered to a patient in an emergency. DBHDS estimates that there are less than 200 occasions where epinephrine or glucagon would need to be administered per year. If the nearby unlicensed individuals providing care to a patient are not trained in epinephrine and glucagon administration, a patient has no choice but to wait for a qualified care provider such as an emergency medical services provider to arrive. According to the Department of Health Professions, the time lost for waiting for such a person could make the difference between life and death.

Businesses and Entities Affected. According to DBHDS, there are about 11,000 staff in group homes and 2,000 staff in sponsored residential facilities that will be affected by the proposed training requirement.

Localities Particularly Affected. The proposed regulations apply throughout the Commonwealth.

Projected Impact on Employment. No significant impact on employment is expected.

Effects on the Use and Value of Private Property. No significant impact on the use and value of private property is expected.

Small Businesses: Costs and Other Effects. No costs or other effects on small businesses are expected.

Small Businesses: Alternative Method that Minimizes Adverse Impact. The proposed regulations do not pose an adverse impact on small businesses.

Real Estate Development Costs. No impact on real estate development costs is expected.

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 14 (10). Section 2.2-4007.04 requires that such economic impact

Regulations

analyses include, but need not be limited to, a determination of the public benefit, 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 an 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 Economic Impact Analysis: The Board of Nursing concurs with the analysis of the Department of Planning and Budget on the proposed amendments to 18VAC90-21, Medication Administration Training and Immunization Protocol.

Summary:

Pursuant to Chapter 183 of the 2013 Acts of Assembly, the proposed amendments provide for the medication administration training curriculum to include training in (i) the signs of hypoglycemia and administration of glucagon and (ii) epinephrine and glucagon administration for the classroom instruction established by the Board of Nursing for the employees of the Department of Behavioral Health and Developmental Services (DBHDS) or persons providing services based on a written contract with a provider licensed by DBHDS.

18VAC90-21-30. Content of medication administration training.

The curriculum shall include a minimum of 32 hours of classroom instruction and practice in the following:

1. Preparing for safe administration of medications to clients in specific settings by:
 - a. Demonstrating an understanding of the client's rights regarding medications, treatment decisions, and confidentiality.
 - b. Recognizing emergencies and other health-threatening conditions and responding accordingly.
 - c. Identifying medication terminology and abbreviations.
2. Maintaining aseptic conditions by:
 - a. Implementing universal precautions.

- b. Insuring cleanliness and disinfection.
 - c. Disposing of infectious or hazardous waste.
3. Facilitating client self-administration or assisting with medication administration by:
 - a. Reviewing administration records and prescriber's orders.
 - b. Facilitating client's awareness of the purpose and effects of medication.
 - c. Assisting the client to interpret prescription labels.
 - d. Observing the five rights of medication administration and security requirements appropriate to the setting.
 - e. Following proper procedure for preparing medications.
 - f. Measuring and recording vital signs to assist the client in making medication administration decisions.
 - g. Assisting the client to administer oral medications.
 - h. Assisting the client with administration of prepared instillations and treatments of:
 - (1) Eye drops and ointments.
 - (2) Ear drops.
 - (3) Nasal drops and sprays.
 - (4) Topical preparations.
 - (5) Compresses and dressings.
 - (6) Vaginal and rectal products.
 - (7) Soaks and sitz baths.
 - (8) Inhalation therapy.
 - (9) Oral hygiene products.
 - i. Reporting and recording the client's refusal to take medication.
 - j. Documenting medication administration.
 - k. Documenting and reporting medication errors.
 - l. Maintaining client records according to facility policy.
 - m. Sharing information with other staff orally and by using documents.
 - n. Storing and securing medications.
 - o. Maintaining an inventory of medications.
 - p. Disposing of medications.
4. Facilitating client self-administration or assisting with the administration of insulin. Instruction and practice in the administration of insulin shall be included only in those settings where required by client needs and shall include:
 - a. Cause and treatment of diabetes.
 - b. The side effects of insulin.
 - c. Preparation and administration of insulin.
 - d. Signs of severe hypoglycemia and administration of glucagon.
5. Facilitating client self-administration or assisting with the administration of auto-injectable epinephrine pursuant

to an order issued by the prescriber for a specific client in a facility licensed by the Department of Behavioral Health and Developmental Services under the provisions of subsection D of § 54.1-3408 of the Code of Virginia.

V.A.R. Doc. No. R15-3819; Filed October 2, 2014, 3:23 p.m.

GOVERNOR

EXECUTIVE ORDER NUMBER 30 (2014)

Marriage Equality in the Commonwealth of Virginia

Importance of the Issue

The highest priority of state government should be to guarantee every person's right to live, learn, work, and do business, regardless of their race, gender, creed or sexual orientation. This principle guided my first act as Governor when I signed Executive Order #1 banning discrimination in the state workplace based on sexual orientation or gender identity. This principle also guided the Virginia leaders, advocates and allies who fought for marriage equality and won when the Supreme Court declined to review the Fourth Circuit Court of Appeals' ruling in *Bostic v. Schaefer*. Same-sex marriage is now legal in Virginia. This is a historic and long overdue moment for our Commonwealth and our country.

The decision has opened new doors to my administration's guiding principle of equality. An open and welcoming environment is imperative to grow as a Commonwealth, and to build a new Virginia economy that will attract vital businesses, innovative entrepreneurs, and thriving families.

On issues ranging from recognizing same-sex marriages to extending health care benefits to same-sex spouses of state employees, state government is already well-prepared to implement this landmark decision. My administration will act quickly to continue to bring all of our policies and practices into compliance so that we can give married same-sex couples the full array of benefits they deserve.

Pursuant to the authority vested in me as the Chief Executive Officer of the Commonwealth, and pursuant to Article V of the Constitution and the laws of Virginia, I hereby order, effective immediately, that all entities in the executive branch, including agencies, authorities, commissions, departments, and all institutions of higher education further evaluate all policies and take all necessary and appropriate legal measures to comply with this decision.

In addition, the Director of the Department of Human Resource Management shall notify all state agencies that employees whose same-sex marriage is recognized as legal in the Commonwealth, and who are eligible, may enroll their spouse and eligible dependents in the health benefits program for state employees within sixty (60) days of marriage.

A full and complete report of all appropriate measures will be reviewed by the Counselor to the Governor and presented to the Governor on or before November 15, 2014.

Effective Date of the Executive Order

This Executive Order shall become effective upon its signing, and shall remain in full force and effect unless amended or rescinded by further executive order.

Given under my hand and under the Seal of the Commonwealth of Virginia this 7th day of October, 2014.

/s/ Terence R. McAuliffe
Governor

EXECUTIVE ORDER NUMBER 31 (2014)

Conserving Energy and Reducing Consumption in the Commonwealth of Virginia

Importance of the Issue

The cleanest and cheapest energy is energy that is not consumed. Strong energy efficiency measures in government, businesses, and residences can reduce energy consumption, costs, and bills, diminish the need to build new generation infrastructure, and increase Virginians' quality of life through lower carbon emissions polluting the atmosphere. Increased energy efficiency measures will serve as a stimulus to the growing energy efficiency industry in Virginia, helping create new jobs and diversifying our economy. The Commonwealth of Virginia will demonstrate the extraordinary potential and invaluable business advantages achieved with energy efficiency.

As a prudent steward of taxpayer dollars, Virginia is dedicated to finding creative solutions with increasingly limited resources. Pursuing sensible energy efficiency in state government will increase the productivity of the energy used, reduce consumption, save money, and lessen any negative environmental impact. The Commonwealth is seeking to reduce electricity consumption in state facilities by 15% by 2017, using 2009-2010 as a baseline.

While the Commonwealth embraces the challenge of reducing energy consumption, localities, businesses, and individual consumers are encouraged to use energy efficiently, and utilize available tools to conserve energy.

Energy Efficiency Initiatives

By the power vested in me by Article V of the Constitution of Virginia, and § 2.2-103 of the Code of Virginia, and subject always to my continuing and ultimate authority and responsibility to act in such matters, I hereby direct all executive branch agencies, authorities, departments, and all institutions of higher education, to every extent practicable, to operate in accordance with the following guidelines:

- All state agencies should proactively pursue energy efficiency measures, especially Energy Performance Contracting (EPC), to reduce energy consumption. EPC is a budget neutral, cost-effective tool that permits state agencies and publicly-owned facilities to reduce their deferred maintenance backlogs without adding any financial burden to the taxpayer. In addition, EPC is an effective mechanism to finance capital improvements using leveraged energy savings to reduce both energy costs and

consumption. For agencies that have already employed EPC, overall energy consumption should be re-evaluated to identify areas for further efficiency improvements.

- Agencies should utilize the current process, at no cost to the agency, which provides for a general audit to assess whether EPC is appropriate for the agency. This portion of the process is managed by the Department of Mines, Minerals and Energy (DMME), and all agencies should work with DMME to have a general audit conducted with the goal of implementing an EPC by 2016.

I have appointed the Advisor for Infrastructure and Development as the Commonwealth's Chief Energy Efficiency Officer (CEEEO) to oversee planning, implementation, and measurement of energy efficiency throughout state government, as follows:

- Organize a meeting with all agencies tasked with overseeing EPC in state government and state-certified Energy Service Companies (ESCOs) to establish a fully transparent, streamlined, and standardized process that agencies will use to implement EPC. This will include the development of an "EPC Roadmap" that will lay out each step of the EPC process, and ensure accountability among agencies and the ESCOs at each stage of project development and implementation.
- Coordinate with SCHEV to identify the deferred maintenance needs at each higher education institution and the opportunities to leverage energy savings to fund building infrastructure upgrades.
- Work with the Department of General Services (DGS) and DMME to identify and prioritize state facilities that offer opportunities for significant cost and consumption reduction.
- Work with DMME to establish a comprehensive system to measure, verify, and track energy consumption in state facilities.
- Re-commission electrical equipment and systems in publicly-owned facilities, when needed.
- Ensure that DMME reviews all annual project performance reports submitted by ESCOs to the agencies.
- Work with subject matter experts to identify best practices to incentivize individuals and agencies regarding energy efficiency measures. Those who show leadership in energy efficiency, regardless of agency and project size, will be recognized.

Effective Date of the Executive Order

This Executive Order shall be effective upon signing and shall remain in force and effect from its signing unless amended or rescinded by further executive order.

Given under my hand and under the Seal of the Commonwealth of Virginia, this 16th day of October, 2014.

/s/ Terence R. McAuliffe
Governor

GENERAL NOTICES/ERRATA

DEPARTMENT OF ENVIRONMENTAL QUALITY Notice of Intent for Small Solar Energy Project - Eastern Shore Solar LLC

On October 14, 2014, Eastern Shore Solar LLC (Eastern Shore Solar) submitted a notice of intent (NOI) to the Department of Environmental Quality (DEQ) for a small solar energy project. In accordance with 9VAC15-60-30 A 1 of the Small Renewable Energy Projects (Solar) Permit by Rule regulation, a NOI is to be submitted to DEQ and is to be published in the Virginia Register as notification that Eastern Shore Solar intends to submit the necessary documentation for a permit by rule for a small renewable solar energy project pursuant to 9VAC15-60.

Proposed Project: Eastern Shore Solar is proposing a small solar energy project consisting of four subprojects. Each subproject will have a maximum capacity of 20 megawatts alternating current (AC), for a total combined maximum capacity of 80 megawatts (MW) AC. The combined 80 MW of subprojects will be sited across roughly 1,000 acres and across multiple parcels.

The four subprojects will utilize traditional photovoltaic solar modules and rotate throughout the day to track the sun. The four subprojects may ultimately be broken out, such that separate permits may be requested from DEQ pursuant to this notice.

Proposed Site Location: Northern Accomack County, west of Route 13 around the Oak Hall Electrical Substation in the general vicinity of Withams and Miona, Virginia.

Contact Information: Mary E. Major, Department of Environmental Quality, 629 East Main Street, P.O. Box 1105, Richmond, VA 23218, email mary.major@deq.virginia.gov, telephone (804) 698-4579, or FAX (804) 698-4019.

STATE WATER CONTROL BOARD

Proposed Enforcement Action for Matchpoint Associates, L.C.

An enforcement action has been proposed for Matchpoint Associates, L.C. for alleged violations at the Matchpoint Apartments at 5846-B Westover Drive, Richmond, VA. The enforcement action requires corrective action and payment of a civil charge. A description of the proposed action is available at the Department of Environmental Quality office named below or online at <http://www.deq.virginia.gov>. Frank Lupini will accept comments by email at frank.lupini@deq.virginia.gov, FAX at (804) 527-5106, or postal mail at Department of Environmental Quality, Piedmont Regional Office, 4949-A Cox Road, Glen Allen, VA 23060, from November 3, 2014, through December 4, 2014.

Proposed Enforcement Action for Plains Marketing, L.P.

An enforcement action has been proposed for Plains Marketing, L.P. for alleged violations of the State Water Control Law in Yorktown, Virginia. A description of the proposed action is available at the Department of Environmental Quality office named below or online at <http://www.deq.virginia.gov>. Mr. Robin Schuhmann will accept comments by email at robin.schuhmann@deq.virginia.gov, FAX at (757) 518-2009, or postal mail at Department of Environmental Quality, Tidewater Regional Office, 5636 Southern Boulevard, Virginia Beach, VA 23462, from November 3, 2014, through December 3, 2014.

Proposed Consent Order for Silver Communications, Inc.

An enforcement action has been proposed for Silver Communications, Inc. for alleged violations at the Silver Communications Printing Facility located in Loudoun County, Virginia. The action seeks to resolve the unauthorized discharge of oil to state waters. The consent order describes a settlement to resolve these violations. A description of the proposed action is available at the Department of Environmental Quality office named below or online at <http://www.deq.virginia.gov>. Daniel Burstein will accept comments by email at daniel.burstein@deq.virginia.gov, FAX at (703) 583-3821, or postal mail at Department of Environmental Quality, Northern Regional Office, 13901 Crown Court, Woodbridge, VA 22193, from November 4, 2013, through December 4, 2014.

Virginia Clean Water Revolving Loan Fund - FY2015 Priority List

Introduction: Section 606(c) of the Water Quality Act of 1987 requires the Commonwealth to develop an annual plan that identifies the intended uses of its Clean Water Revolving Loan Fund and to prepare a list of projects targeted for financial assistance with those funds. Following public comment and final board action, the list of targeted projects for financial assistance becomes the Commonwealth's yearly Clean Water Revolving Loan Fund Project Priority List.

Funds Available: The federal appropriation for the nation's Clean Water State Revolving Funds for FY 2015 has not been approved yet but Virginia's share is expected to be in the range of \$20 million. State matching appropriations, along with the accumulation of moneys through loan repayments and prepayments, interest earnings, and de-allocations from leverage accounts should make an additional \$70 million available for funding new projects. These funds, in accumulation, will result in at least \$90 million becoming available during the 2015 funding cycle.

FY 2015 Program Development: On May 30, 2014, the staff solicited applications from the Commonwealth's localities and wastewater authorities as well as potential land conservation applicants and Brownfield remediation clientele. July 18, 2014, was established as the deadline for receiving applications. Based on this solicitation, Department of Environmental Quality (DEQ) received 15 wastewater improvement applications requesting \$60,901,278; eight applications for land conservation projects (totaling \$21,869,300); and one stormwater management application for an additional \$1,195,000, bringing the total amount requested to \$83,965,578.

All 15 wastewater applications were evaluated in accordance with the program's funding distribution criteria. In keeping with the program objectives and funding prioritization criteria, the staff reviewed project type and impact on state waters, the locality's compliance history and fiscal stress, and the project's readiness-to-proceed. The eight land conservation applications were reviewed using the board's land conservation loan funding prioritization criteria and the staff also received input from the Department of Conservation and Recreation in accordance with the board's guidelines and state law. The one stormwater application was reviewed in accordance with the board's priority ranking criteria for stormwater projects. The list of applications is shown below by project type in priority funding order based on the board's prioritization criteria. All applications are considered to be of good quality and should provide significant water quality and environmental improvement.

Based on these considerations, on September 29, 2014, the board approved the staff recommendation to authorize funding for \$83,965,578 for all 24 projects as shown below.

Public Participation: The board is presenting its draft list of targeted FY 2015 loan recipients for public review and comment. A public meeting will be held at 2 p.m. on Wednesday, November 12, 2014, in the Department of Environmental Quality's 2nd Floor Conference Room, 629 East Main Street, Richmond, VA 23219. The public review and comment period will end immediately following the public meeting. Comments or questions should be directed to the following contact: Walter Gills, Department of Environmental Quality, Clean Water Financing and Assistance Program, 629 East Main Street, P.O. Box 1105, Richmond, VA 23218, telephone (804) 698-4133, or email walter.gills@deq.virginia.gov. Written comments should include the name, address, and telephone number of the presenter.

Project Priority List:

Applicant	Requested Amount
City of Norfolk	\$6,000,000
City of Waynesboro	\$1,723,401

Rivanna WSA	\$3,418,174
Buchanan County PSA	\$16,204,121
Town of Surry	\$2,020,400
Middle Peninsula PDC	\$200,000
Alleghany County	\$1,612,720
Town of Broadway	\$6,565,000
Town of Rural Retreat	\$862,550
Washington County SA	\$1,171,550
Harrisonburg/Rockingham RSA	\$8,995,500
Alleghany County	\$1,000,000
Town of Honaker	\$396,171
Tazewell County PSA	\$10,586,691
Alleghany County	\$145,000
City of Norfolk	\$1,195,000
Virginia Conservation Legacy Fund	\$5,160,000
Virginia Conservation Legacy Fund	\$5,169,000
Virginia Conservation Legacy Fund	\$5,215,000
Virginia Conservation Legacy Fund	\$3,103,000
Virginia Conservation Legacy Fund	\$597,000
Virginia Conservation Legacy Fund	\$2,073,000
Town of Marion	\$127,300
Virginia Conservation Legacy Fund	\$425,000
	\$83,965,578

VIRGINIA CODE COMMISSION

Notice to State Agencies

Contact Information: *Mailing Address:* Virginia Code Commission, General Assembly Building, 201 North 9th Street, 2nd Floor, Richmond, VA 23219; *Telephone:* Voice (804) 786-3591; FAX (804) 692-0625; *Email:* varegs@dls.virginia.gov.

Meeting Notices: Section 2.2-3707 C of the Code of Virginia requires state agencies to post meeting notices on their websites and on the Commonwealth Calendar at <http://www.virginia.gov/connect/commonwealth-calendar>.

Cumulative Table of Virginia Administrative Code Sections Adopted, Amended, or Repealed: A table listing regulation sections that have been amended, added, or repealed in the *Virginia Register of Regulations* since the regulations were originally published or last supplemented in the print version of the Virginia Administrative Code is

General Notices/Errata

available at
<http://register.dls.virginia.gov/documents/cumultab.pdf>.

Filing Material for Publication in the *Virginia Register of Regulations*: Agencies use the Regulation Information System (RIS) to file regulations and related items for publication in the *Virginia Register of Regulations*. The Registrar's office works closely with the Department of Planning and Budget (DPB) to coordinate the system with the Virginia Regulatory Town Hall. RIS and Town Hall complement and enhance one another by sharing pertinent regulatory information.