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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>).

January 2015 through March 2016

<u>Volume: Issue</u>	<u>Material Submitted By Noon*</u>	<u>Will Be Published On</u>
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
32:9	December 9, 2015	December 28, 2015
32:10	December 21, 2015 (Monday)	January 11, 2016
32:11	January 6, 2016	January 25, 2016
32:12	January 20, 2016	February 8, 2016
32:13	February 3, 2016	February 22, 2016
32:14	February 17, 2016	March 7, 2016

*Filing deadlines are Wednesdays unless otherwise specified.

NOTICES OF INTENDED REGULATORY ACTION

TITLE 12. HEALTH

STATE BOARD OF HEALTH

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the State Board of Health intends to consider amending **12VAC5-71, Regulations Governing Virginia Newborn Screening Services**, and **12VAC5-191, State Plan for the Children with Special Health Care Needs Program**. The purpose of the proposed action is to add critical congenital heart disease screening to the Virginia Newborn Screening System as mandated by Chapters 4 and 175 of the 2014 Acts of Assembly.

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

Statutory Authority: §§ 32.1-12, 32.1-65.1, and 32.1-67 of the Code of Virginia.

Public Comment Deadline: February 25, 2015.

Agency Contact: Dev Nair, Director, Division of Policy and Evaluation, Department of Health, 109 Governor Street, Richmond, VA 23219, telephone (804) 864-7662, FAX (804) 864-7647, or email dev.nair@vdh.virginia.gov.

VA.R. Doc. No. R15-4176; Filed December 24, 2014, 10:13 a.m.

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 Department of Medical Assistance Services intends to consider amending **12VAC30-120, Waivered Services**. The purpose of the proposed action is to implement several mandates from various legislative actions to require (i) individuals who are participating in a home and community-based care services waiver, specifically the Elderly or Disabled with Consumer Direction waiver, to also be enrolled in Medicaid contracted managed care organizations and (ii) expedited enrollment for Medicaid individuals into Medicaid contracted managed care organizations, especially pregnant women.

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: February 25, 2015.

Agency Contact: Victoria Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-6043, FAX (804) 786-1680, TTY (800) 343-0634, or email victoria.simmons@dmas.virginia.gov.

VA.R. Doc. No. R15-4135; Filed December 29, 2014, 1:20 p.m.

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the Department of Medical Assistance Services intends to consider amending **12VAC30-141, Family Access to Medical Insurance Security Plan**. The purpose of the proposed action is to create eligibility for certain children of state employees who otherwise meet the eligibility requirements for the FAMIS program.

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 and 32.1-351 of the Code of Virginia; 42 USC § 1396 et seq.

Public Comment Deadline: February 25, 2015.

Agency Contact: Victoria Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-6043, FAX (804) 786-1680, TTY (800) 343-0634, or email victoria.simmons@dmas.virginia.gov.

VA.R. Doc. No. R15-4206; Filed December 29, 2014, 1:17 p.m.

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARD OF AUDIOLOGY AND SPEECH-LANGUAGE PATHOLOGY

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 Audiology and Speech-Language Pathology intends to consider amending **18VAC30-20, Regulations Governing the Practice of Audiology and Speech-Language Pathology**. The purpose of the proposed action is to provide a framework for safe practice in the performance of cerumen management by audiologists that, before 2014, was not recognized in Virginia as being within the scope of practice of an audiologist. By the change in law and regulation, the practice is expanded to include limited cerumen management, but the qualifications for such practice and the limitations of practice by an audiologist are essential to protect patients.

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

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

Public Comment Deadline: February 25, 2015.

Agency Contact: Leslie L. Knachel, Executive Director, Board of Audiology and Speech-Language Pathology, 9960 Mayland Drive, Suite 300, Richmond, VA 23233-1463, telephone (804) 367-4630, FAX (804) 527-4413, or email leslie.knachel@dhp.virginia.gov.

VA.R. Doc. No. R15-4115; Filed December 29, 2014, 8:33 a.m.

Notices of Intended Regulatory Action

BOARD OF MEDICINE

Withdrawal of 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 Medicine has WITHDRAWN the Notice of Intended Regulatory Action (NOIRA) for **18VAC85-50, Regulations Governing the Practice of Physician Assistants**, which was published in [30:7 VA.R. 805 December 2, 2013](#). The NOIRA is unnecessary as the agency is proceeding with this regulatory action through the fast-track rulemaking process under § 2.2-4012.1 of the Code of Virginia. The fast-track rulemaking action was published in [31:9 VA.R. 730 December 29, 2014](#).

Agency Contact: William L. Harp, M.D., Executive Director, Board of Medicine, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4558, FAX (804) 527-4429, or email william.harp@dhp.virginia.gov.

VA.R. Doc. No. R14-3348; Filed January 13, 2015, 11:43 a.m.

BOARD OF NURSING

Withdrawal of 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 Nursing has WITHDRAWN the Notice of Intended Regulatory Action (NOIRA) for **18VAC90-20, Regulations Governing the Practice of Nursing**, which was published in [30:5 VA.R. 459 November 4, 2013](#). The NOIRA is unnecessary as the agency is proceeding with this regulatory action through the fast-track rulemaking process under § 2.2-4012.1 of the Code of Virginia. The fast-track rulemaking action was published in [31:9 VA.R. 737 December 29, 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.

VA.R. Doc. No. R14-3733; Filed January 13, 2015, 11:45 a.m.

REGULATIONS

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

Symbol Key

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

TITLE 9. ENVIRONMENT

STATE AIR POLLUTION CONTROL BOARD

Fast-Track Regulation

Title of Regulation: **9VAC5-10. General Definitions (Rev. H13) (amending 9VAC5-10-20).**

Statutory Authority: § 10.1-1308 of the Code of Virginia.

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: February 25, 2015.

Effective Date: March 12, 2015.

Agency Contact: Karen G. Sabasteanski, Department of Environmental Quality, 629 East Main Street, P.O. Box 1105, Richmond, VA 23218, telephone (804) 698-4426, FAX (804) 698-4510, TTY (804) 698-4021, or email karen.sabasteanski@deq.virginia.gov.

Basis: Section 10.1-1308 of the Virginia Air Pollution Control Law (Chapter 13 (§ 10.1-1300 et seq.) of Title 10.1 of the Code of Virginia) authorizes the State Air Pollution Control Board to promulgate regulations abating, controlling, and prohibiting air pollution in order to protect public health and welfare.

Federal Requirements: Section 109(a) of the federal Clean Air Act requires the U.S. Environmental Protection Agency (EPA) to prescribe national ambient air quality standards (NAAQS) to protect public health. Section 110 mandates that each state adopt and submit to EPA a state implementation plan (SIP) that provides for the implementation, maintenance, and enforcement of the NAAQS. Ozone, one of the pollutants for which there is a NAAQS, is in part created by emissions of volatile organic compounds (VOCs). Therefore, in order to control ozone, VOCs must be addressed in Virginia's SIP.

40 CFR Part 51 sets out requirements for the preparation, adoption, and submittal of SIPs. Subpart F of Part 51, Procedural Requirements, includes § 51.100, which consists of a list of definitions. 40 CFR 51.100 contains a definition of VOC. This definition is revised by EPA to add or remove VOCs as necessary. If, for example, it can be demonstrated that a particular VOC is "negligibly reactive"--that is, if it can be shown that a VOC is not as reactive and therefore does not have a significant effect on ground-level or upper atmospheric ozone--then EPA may remove that substance from the definition of VOC.

EPA originally proposed approval of a revision to the definition of VOC in 40 CFR 51.100 to exclude trans 1-chloro-3,3,3-trifluoroprop-1-ene (also known as Solstice™

1233zd(E)) on February 15, 2013 (78 FR 11101). On August 28, 2013 (78 FR 53029), EPA finalized this change to the VOC exemption list, which became effective on September 27, 2013. On October 22, 2013 (78 FR 62451), EPA further revised the definition of VOC to exclude 2,3,3,3-tetrafluoropropene (also known as HFO-1234yf), which became effective on November 21, 2013.

State Requirements: These specific amendments are not required by state mandate. Rather, Virginia's Air Pollution Control Law gives the State Air Pollution Control Board the discretionary authority to promulgate regulations "abating, controlling and prohibiting air pollution throughout or in any part of the Commonwealth" (§ 10.1-1308 A of the Code of Virginia). The law defines such air pollution as "the presence in the outdoor atmosphere of one or more substances which are or may be harmful or injurious to human health, welfare or safety, to animal or plant life, or to property, or which unreasonably interfere with the enjoyment by the people or life or property" (§ 10.1-1300 of the Code of Virginia).

Purpose: The purpose of the regulation (general definitions) is not to impose any regulatory requirements in and of itself, but to provide a basis for and support to other provisions of the board's regulations for the control and abatement of air pollution, which are in place in order to protect public health and welfare. The proposed amendments are being made to ensure that the definition of VOC, which is crucial to most of the regulations, is up to date and scientifically accurate, as well as consistent with the overall EPA requirements under which the regulations operate.

Rationale for Using Fast-Track Process: The definition of VOC is being revised to add two less-reactive substances to the list of compounds not considered to be VOCs. As discussed elsewhere, these amendments are not expected to affect a significant number of sources or have any significant impact, other than a positive one, on air quality overall. Additionally, removal of these substances at the federal level was accompanied by detailed scientific review and public comment. Therefore, no additional information on the reactivity of these substances or the appropriateness of their removal is anticipated.

Substance: The general definitions impose no regulatory requirements in and of themselves but provide support to other provisions of the board's regulations for the control and abatement of air pollution. The list of substances not considered to be VOCs in Virginia has been revised to include trans 1-chloro-3,3,3-trifluoroprop-1-ene (also known as Solstice™ 1233zd(E)) and 2,3,3,3-tetrafluoropropene (also known as HFO-1234yf).

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Issues: The general public health and welfare will benefit because the revisions may encourage the use of the delisted substances in place of products containing more reactive and thereby more polluting substances. These substances are considered to be negligibly reactive in the formation of ground level (tropospheric) ozone and will not deplete upper level (stratospheric) ozone. Therefore, these substances do not have a negative effect on human health or the environment.

Excluding these substances as VOCs will make it easier and less expensive for industry to use them. Companies that use these substances in place of more reactive substances may also benefit by reducing their VOC emissions and concomitant reductions in permitting and other regulatory requirements.

The amendments will allow the department to focus VOC reduction strategies on substances that have a negative impact on human health and the environment.

There are no known disadvantages to the public, the department, or the Commonwealth.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The State Air Pollution Control Board (Board) proposes to revise the definition of volatile organic compound (VOC) to include trans 1-chloro-3,3,3-trifluoroprop-1-ene and 2,3,3,3-tetrafluoropropene on the list of compounds not considered to be VOC.

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

Estimated Economic Impact. The general definitions of 9VAC5-10 impose no regulatory requirements in and of themselves, but provide support to other Board regulations. The U.S. Environmental Protection Agency has revised the definition of VOC to add two compounds that have been demonstrated to be less reactive to the list of compounds that are not considered to be VOCs: trans 1-chloro-3,3,3-trifluoroprop-1-ene (also known as Solstice™ 1233zd(E)) and 2,3,3,3-tetrafluoropropene (also known as HFO-1234yf). Consequently, the Board proposed to update the list of compounds not considered to be VOC.

Trans 1-chloro-3,3,3-trifluoroprop-1-ene may be used in insulation foams as blowing agent in insulating foams for refrigerators/freezers/hot water heaters and 2,3,3,3-tetrafluoropropene may be used as refrigerant in commercial chillers and waste heat recovery systems. The Department of Environmental Quality is not aware of any sources located in Virginia that currently use these substances. There are sources that may someday eventually wish to use them; however, DEQ has not identified any specific sources that plan to do so.

The general public health and welfare may benefit because the revision may encourage the use of these compounds in place of products containing more reactive, and thereby more

polluting, substances. Due to their low photochemical reactivity, these compounds are considered to be negligibly reactive in the formation of tropospheric (ground level) ozone and are not expected to contribute to violations of the federal national ambient air quality standards. These compounds are not hazardous air pollutants, and will not deplete stratospheric (upper atmosphere) ozone. Therefore, they do not have a negative effect on human health or the environment.

Excluding these compounds as VOCs will make them easier and less expensive for industry to use. Companies that use these compounds in place of more reactive substances may also benefit by reducing their VOC emissions and concomitant reductions in permitting and other regulatory requirements. Thus, the proposal to add these compounds to the list of substances not considered to be VOC will create a net benefit.

Businesses and Entities Affected. One of these compounds may be used in insulation foams as blowing agent in insulating foams for refrigerators/freezers/hot water heaters and the other may be used as refrigerant in commercial chillers and waste heat recovery systems. Consequently, the proposal to add them to the list of substances not considered to be VOC will potentially affect firms which may start manufacturing products that contain these compounds.

Localities Particularly Affected. The proposal to add two new compounds to the list of substances not considered to be VOC does not have a disproportionate effect on any particular localities.

Projected Impact on Employment. The proposed amendment will not likely have a large impact on employment.

Effects on the Use and Value of Private Property. The proposal to add two new compounds to the list of substances not considered to be VOC will have no immediate impact since currently there are no known firms located in Virginia that currently use these compounds. Adding these compounds to the list of substances not considered to be VOC will make them less costly to use, which may encourage firms to start using them in production. Thus, the proposed amendment may eventually affect some firms production methods, lower their costs, and consequently moderately increase firm value.

Small Businesses: Costs and Other Effects. The proposal to add two new compounds to the list of substances not considered to be VOC will have no immediate impact since currently there are no known firms located in Virginia that currently use these compounds. Adding them to the list of substances not considered to be VOC will make them less costly to use. Thus, some small firms may eventually use these compounds to lower costs.

Small Businesses: Alternative Method that Minimizes Adverse Impact. The proposed amendment will not adversely affect small businesses.

Real Estate Development Costs. The proposed amendment will not likely have a large impact on real estate development costs.

Legal Mandate. The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007.04 of the Administrative Process Act and Executive Order Number 14 (10). Section 2.2-4007.04 requires that such economic impact 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 department has reviewed the economic impact analysis prepared by the Department of Planning and Budget and has no comment.

Summary:

The amendment revises the definition of volatile organic compound (VOC) to add trans 1-chloro-3,3,3-trifluoroprop-1-ene (also known as Solstice™ 1233zd(E)) and 2,3,3,3-tetrafluoropropene (also known as HFO-1234yf) to the list of compounds excluded from the definition of VOC.

9VAC5-10-20. Terms defined.

"Actual emissions rate" means the actual rate of emissions of a pollutant from an emissions unit. In general actual emissions shall equal the average rate, in tons per year, at which the unit actually emitted the pollutant during the most recent two-year period or some other two-year period which is representative of normal source operation. If the board determines that no two-year period is representative of normal source operation, the board shall allow the use of an alternative period of time upon a determination by the board that it is more representative of normal source operation. Actual emissions shall be calculated using the unit's actual operating hours, production rates, and types of materials

processed, stored, or combusted during the selected time period.

"Administrator" means the administrator of the U.S. Environmental Protection Agency (EPA) or his authorized representative.

"Affected facility" means, with reference to a stationary source, any part, equipment, facility, installation, apparatus, process or operation to which an emission standard is applicable or any other facility so designated. The term "affected facility" includes any affected source as defined in 40 CFR 63.2.

"Air pollution" means the presence in the outdoor atmosphere of one or more substances which are or may be harmful or injurious to human health, welfare or safety; to animal or plant life; or to property; or which unreasonably interfere with the enjoyment by the people of life or property.

"Air quality" means the specific measurement in the ambient air of a particular air pollutant at any given time.

"Air quality control region" means any area designated as such in 9VAC5-20-200.

"Alternative method" means any method of sampling and analyzing for an air pollutant which is not a reference or equivalent method, but which has been demonstrated to the satisfaction of the board, in specific cases, to produce results adequate for its determination of compliance.

"Ambient air" means that portion of the atmosphere, external to buildings, to which the general public has access.

"Ambient air quality standard" means any primary or secondary standard designated as such in 9VAC5-30 (Ambient Air Quality Standards).

"Board" means the State Air Pollution Control Board or its designated representative.

"Certified mail" means electronically certified or postal certified mail, except that this definition shall only apply to the mailing of plan approvals, permits, or certificates issued under the provisions of these regulations and only where the recipient has notified the department of the recipient's consent to receive plan approvals, permits, or certificates by electronic mail. Any provision of these regulations requiring the use of certified mail to transmit special orders or administrative orders pursuant to enforcement proceedings shall mean postal certified mail.

"Class I area" means any prevention of significant deterioration area (i) in which virtually any deterioration of existing air quality is considered significant and (ii) designated as such in 9VAC5-20-205.

"Class II area" means any prevention of significant deterioration area (i) in which any deterioration of existing air quality beyond that normally accompanying well-controlled growth is considered significant and (ii) designated as such in 9VAC5-20-205.

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"Class III area" means any prevention of significant deterioration area (i) in which deterioration of existing air quality to the levels of the ambient air quality standards is permitted and (ii) designated as such in 9VAC5-20-205.

"Continuous monitoring system" means the total equipment used to sample and condition (if applicable), to analyze, and to provide a permanent continuous record of emissions or process parameters.

"Control program" means a plan formulated by the owner of a stationary source to establish pollution abatement goals, including a compliance schedule to achieve such goals. The plan may be submitted voluntarily, or upon request or by order of the board, to ensure compliance by the owner with standards, policies and regulations adopted by the board. The plan shall include system and equipment information and operating performance projections as required by the board for evaluating the probability of achievement. A control program shall contain the following increments of progress:

1. The date by which contracts for emission control system or process modifications are to be awarded, or the date by which orders are to be issued for the purchase of component parts to accomplish emission control or process modification.
2. The date by which the on-site construction or installation of emission control equipment or process change is to be initiated.
3. The date by which the on-site construction or installation of emission control equipment or process modification is to be completed.
4. The date by which final compliance is to be achieved.

"Criteria pollutant" means any pollutant for which an ambient air quality standard is established under 9VAC5-30 (Ambient Air Quality Standards).

"Day" means a 24-hour period beginning at midnight.

"Delayed compliance order" means any order of the board issued after an appropriate hearing to an owner which postpones the date by which a stationary source is required to comply with any requirement contained in the applicable implementation plan.

"Department" means any employee or other representative of the Virginia Department of Environmental Quality, as designated by the director.

"Director" or "executive director" means the director of the Virginia Department of Environmental Quality or a designated representative.

"Dispersion technique"

1. Means any technique which attempts to affect the concentration of a pollutant in the ambient air by:
 - a. Using that portion of a stack which exceeds good engineering practice stack height;

- b. Varying the rate of emission of a pollutant according to atmospheric conditions or ambient concentrations of that pollutant; or

- c. Increasing final exhaust gas plume rise by manipulating source process parameters, exhaust gas parameters, stack parameters, or combining exhaust gases from several existing stacks into one stack; or other selective handling of exhaust gas streams so as to increase the exhaust gas plume rise.

2. The preceding sentence does not include:

- a. The reheating of a gas stream, following use of a pollution control system, for the purpose of returning the gas to the temperature at which it was originally discharged from the facility generating the gas stream;

- b. The merging of exhaust gas streams where:

- (1) The owner demonstrates that the facility was originally designed and constructed with such merged gas streams;

- (2) After July 8, 1985, such merging is part of a change in operation at the facility that includes the installation of pollution controls and is accompanied by a net reduction in the allowable emissions of a pollutant. This exclusion from the definition of "dispersion techniques" shall apply only to the emissions limitation for the pollutant affected by such change in operation; or

- (3) Before July 8, 1985, such merging was part of a change in operation at the facility that included the installation of emissions control equipment or was carried out for sound economic or engineering reasons. Where there was an increase in the emissions limitation or, in the event that no emissions limitation was in existence prior to the merging, an increase in the quantity of pollutants actually emitted prior to the merging, the board shall presume that merging was significantly motivated by an intent to gain emissions credit for greater dispersion. Absent a demonstration by the owner that merging was not significantly motivated by such intent, the board shall deny credit for the effects of such merging in calculating the allowable emissions for the source;

- c. Smoke management in agricultural or silvicultural prescribed burning programs;

- d. Episodic restrictions on residential woodburning and open burning; or

- e. Techniques under subdivision 1 c of this definition which increase final exhaust gas plume rise where the resulting allowable emissions of sulfur dioxide from the facility do not exceed 5,000 tons per year.

"Emergency" means a situation that immediately and unreasonably affects, or has the potential to immediately and unreasonably affect, public health, safety or welfare; the health of animal or plant life; or property, whether used for

recreational, commercial, industrial, agricultural or other reasonable use.

"Emissions limitation" means any requirement established by the board which limits the quantity, rate, or concentration of continuous emissions of air pollutants, including any requirements which limit the level of opacity, prescribe equipment, set fuel specifications, or prescribe operation or maintenance procedures to assure continuous emission reduction.

"Emission standard" means any provision of 9VAC5-40 (Existing Stationary Sources), 9VAC5-50 (New and Modified Stationary Sources), or 9VAC5-60 (Hazardous Air Pollutant Sources) that prescribes an emissions limitation, or other requirements that control air pollution emissions.

"Emissions unit" means any part of a stationary source which emits or would have the potential to emit any air pollutant.

"Equivalent method" means any method of sampling and analyzing for an air pollutant which has been demonstrated to the satisfaction of the board to have a consistent and quantitative relationship to the reference method under specified conditions.

"EPA" means the U.S. Environmental Protection Agency or an authorized representative.

"Excess emissions" means emissions of air pollutant in excess of an emission standard.

"Excessive concentration" is defined for the purpose of determining good engineering practice (GEP) stack height under subdivision 3 of the GEP definition and means:

1. For sources seeking credit for stack height exceeding that established under subdivision 2 of the GEP definition, a maximum ground-level concentration due to emissions from a stack due in whole or part to downwash, wakes, and eddy effects produced by nearby structures or nearby terrain features which individually is at least 40% in excess of the maximum concentration experienced in the absence of such downwash, wakes, or eddy effects and which contributes to a total concentration due to emissions from all sources that is greater than an ambient air quality standard. For sources subject to the provisions of Article 8 (9VAC5-80-1605 et seq.) of Part II of 9VAC5-80 (Permits for Stationary Sources), an excessive concentration alternatively means a maximum ground-level concentration due to emissions from a stack due in whole or part to downwash, wakes, or eddy effects produced by nearby structures or nearby terrain features which individually is at least 40% in excess of the maximum concentration experienced in the absence of the maximum concentration experienced in the absence of such downwash, wakes, or eddy effects and greater than a prevention of significant deterioration increment. The allowable emission rate to be used in making demonstrations under this provision shall be prescribed by

the new source performance standard that is applicable to the source category unless the owner demonstrates that this emission rate is infeasible. Where such demonstrations are approved by the board, an alternative emission rate shall be established in consultation with the owner;

2. For sources seeking credit after October 11, 1983, for increases in existing stack heights up to the heights established under subdivision 2 of the GEP definition, either (i) a maximum ground-level concentration due in whole or part to downwash, wakes or eddy effects as provided in subdivision 1 of this definition, except that the emission rate specified by any applicable implementation plan (or, in the absence of such a limit, the actual emission rate) shall be used, or (ii) the actual presence of a local nuisance caused by the existing stack, as determined by the board; and

3. For sources seeking credit after January 12, 1979, for a stack height determined under subdivision 2 of the GEP definition where the board requires the use of a field study or fluid model to verify GEP stack height, for sources seeking stack height credit after November 9, 1984, based on the aerodynamic influence of cooling towers, and for sources seeking stack height credit after December 31, 1970, based on the aerodynamic influence of structures not adequately represented by the equations in subdivision 2 of the GEP definition, a maximum ground-level concentration due in whole or part to downwash, wakes or eddy effects that is at least 40% in excess of the maximum concentration experienced in the absence of such downwash, wakes, or eddy effects.

"Existing source" means any stationary source other than a new source or modified source.

"Facility" means something that is built, installed or established to serve a particular purpose; includes, but is not limited to, buildings, installations, public works, businesses, commercial and industrial plants, shops and stores, heating and power plants, apparatus, processes, operations, structures, and equipment of all types.

"Federal Clean Air Act" means Chapter 85 (§ 7401 et seq.) of Title 42 of the United States Code.

"Federally enforceable" means all limitations and conditions which are enforceable by the administrator and citizens under the federal Clean Air Act or that are enforceable under other statutes administered by the administrator. Federally enforceable limitations and conditions include, but are not limited to, the following:

1. Emission standards, alternative emission standards, alternative emissions limitations, and equivalent emissions limitations established pursuant to § 112 of the federal Clean Air Act as amended in 1990.
2. New source performance standards established pursuant to § 111 of the federal Clean Air Act, and emission

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standards established pursuant to § 112 of the federal Clean Air Act before it was amended in 1990.

3. All terms and conditions in a federal operating permit, including any provisions that limit a source's potential to emit, unless expressly designated as not federally enforceable.

4. Limitations and conditions that are part of an implementation plan.

5. Limitations and conditions that are part of a section 111(d) or section 111(d)/129 plan.

6. Limitations and conditions that are part of a federal construction permit issued under 40 CFR 52.21 or any construction permit issued under regulations approved by EPA in accordance with 40 CFR Part 51.

7. Limitations and conditions that are part of an operating permit issued pursuant to a program approved by EPA into an implementation plan as meeting EPA's minimum criteria for federal enforceability, including adequate notice and opportunity for EPA and public comment prior to issuance of the final permit and practicable enforceability.

8. Limitations and conditions in a Virginia regulation or program that has been approved by EPA under subpart E of 40 CFR Part 63 for the purposes of implementing and enforcing § 112 of the federal Clean Air Act.

9. Individual consent agreements issued pursuant to the legal authority of EPA.

"Good engineering practice" or "GEP," with reference to the height of the stack, means the greater of:

1. 65 meters, measured from the ground-level elevation at the base of the stack;

2. a. For stacks in existence on January 12, 1979, and for which the owner had obtained all applicable permits or approvals required under 9VAC5-80 (Permits for Stationary Sources),

$$H_g = 2.5H,$$

provided the owner produces evidence that this equation was actually relied on in establishing an emissions limitation;

b. For all other stacks,

$$H_g = H + 1.5L,$$

where:

H_g = good engineering practice stack height, measured from the ground-level elevation at the base of the stack,

H = height of nearby structure(s) measured from the ground-level elevation at the base of the stack,

L = lesser dimension, height or projected width, of nearby structure(s) provided that the board may require the use of a field study or fluid model to verify GEP stack height for the source; or

3. The height demonstrated by a fluid model or a field study approved by the board, which ensures that the emissions from a stack do not result in excessive concentrations of any air pollutant as a result of atmospheric downwash, wakes, or eddy effects created by the source itself, nearby structures or nearby terrain features.

"Hazardous air pollutant" means an air pollutant to which no ambient air quality standard is applicable and which in the judgment of the administrator causes, or contributes to, air pollution which may reasonably be anticipated to result in an increase in mortality or an increase in serious irreversible, or incapacitating reversible, illness.

"Implementation plan" means the portion or portions of the state implementation plan, or the most recent revision thereof, which has been approved under § 110 of the federal Clean Air Act, or promulgated under § 110(c) of the federal Clean Air Act, or promulgated or approved pursuant to regulations promulgated under § 301(d) of the federal Clean Air Act and which implements the relevant requirements of the federal Clean Air Act.

"Initial emission test" means the test required by any regulation, permit issued pursuant to 9VAC5-80 (Permits for Stationary Sources), control program, compliance schedule or other enforceable mechanism for determining compliance with new or more stringent emission standards or permit limitations or other emissions limitations requiring the installation or modification of air pollution control equipment or implementation of a control method. Initial emission tests shall be conducted in accordance with 9VAC5-40-30.

"Initial performance test" means the test required by (i) 40 CFR Part 60 for determining compliance with standards of performance, or (ii) a permit issued pursuant to 9VAC5-80 (Permits for Stationary Sources) for determining initial compliance with permit limitations. Initial performance tests shall be conducted in accordance with 9VAC5-50-30 and 9VAC5-60-30.

"Isokinetic sampling" means sampling in which the linear velocity of the gas entering the sampling nozzle is equal to that of the undisturbed gas stream at the sample point.

"Locality" means a city, town, county or other public body created by or pursuant to state law.

"Mail" means electronic or postal delivery.

"Maintenance area" means any geographic region of the United States previously designated as a nonattainment area and subsequently redesignated to attainment subject to the requirement to develop a maintenance plan and designated as such in 9VAC5-20-203.

"Malfunction" means any sudden failure of air pollution control equipment, of process equipment, or of a process to operate in a normal or usual manner, which failure is not due to intentional misconduct or negligent conduct on the part of

the owner or other person. Failures that are caused in part by poor maintenance or careless operation are not malfunctions.

"Monitoring device" means the total equipment used to measure and record (if applicable) process parameters.

"Nearby" as used in the definition of good engineering practice (GEP) is defined for a specific structure or terrain feature and:

1. For purposes of applying the formulae provided in subdivision 2 of the GEP definition means that distance up to five times the lesser of the height or the width dimension of a structure, but not greater than 0.8 km (1/2 mile); and

2. For conducting demonstrations under subdivision 3 of the GEP definition means not greater than 0.8 km (1/2 mile), except that the portion of a terrain feature may be considered to be nearby which falls within a distance of up to 10 times the maximum height (Ht) of the feature, not to exceed two miles if such feature achieves a height (Ht) 0.8 km from the stack that is at least 40% of the GEP stack height determined by the formulae provided in subdivision 2 b of the GEP definition or 26 meters, whichever is greater, as measured from the ground-level elevation at the base of the stack. The height of the structure or terrain feature is measured from the ground-level elevation at the base of the stack.

"Nitrogen oxides" means all oxides of nitrogen except nitrous oxide, as measured by test methods set forth in 40 CFR Part 60.

"Nonattainment area" means any area which is shown by air quality monitoring data or, where such data are not available, which is calculated by air quality modeling (or other methods determined by the board to be reliable) to exceed the levels allowed by the ambient air quality standard for a given pollutant including, but not limited to, areas designated as such in 9VAC5-20-204.

"One hour" means any period of 60 consecutive minutes.

"One-hour period" means any period of 60 consecutive minutes commencing on the hour.

"Organic compound" means any chemical compound of carbon excluding carbon monoxide, carbon dioxide, carbonic disulfide, carbonic acid, metallic carbides, metallic carbonates and ammonium carbonate.

"Owner" means any person, including bodies politic and corporate, associations, partnerships, personal representatives, trustees and committees, as well as individuals, who owns, leases, operates, controls or supervises a source.

"Particulate matter" means any airborne finely divided solid or liquid material with an aerodynamic diameter smaller than 100 micrometers.

"Particulate matter emissions" means all finely divided solid or liquid material, other than uncombined water, emitted to the ambient air as measured by the applicable reference method, or an equivalent or alternative method.

"PM₁₀" means particulate matter with an aerodynamic diameter less than or equal to a nominal 10 micrometers as measured by the applicable reference method or an equivalent method.

"PM₁₀ emissions" means finely divided solid or liquid material, with an aerodynamic diameter less than or equal to a nominal 10 micrometers emitted to the ambient air as measured by the applicable reference method, or an equivalent or alternative method.

"Performance test" means a test for determining emissions from new or modified sources.

"Person" means an individual, corporation, partnership, association, a governmental body, a municipal corporation, or any other legal entity.

"Pollutant" means any substance the presence of which in the outdoor atmosphere is or may be harmful or injurious to human health, welfare or safety, to animal or plant life, or to property, or which unreasonably interferes with the enjoyment by the people of life or property.

"Potential to emit" means the maximum capacity of a stationary source to emit a pollutant under its physical and operational design. Any physical or operational limitation on the capacity of the source to emit a pollutant, including air pollution control equipment, and restrictions on hours of operation or on the type or amount of material combusted, stored, or processed, shall be treated as part of its design only if the limitation or its effect on emissions is state and federally enforceable.

"Prevention of significant deterioration area" means any area not designated as a nonattainment area in 9VAC5-20-204 for a particular pollutant and designated as such in 9VAC5-20-205.

"Proportional sampling" means sampling at a rate that produces a constant ratio of sampling rate to stack gas flow rate.

"Public hearing" means, unless indicated otherwise, an informal proceeding, similar to that provided for in § 2.2-4007.02 of the Administrative Process Act, held to afford persons an opportunity to submit views and data relative to a matter on which a decision of the board is pending.

"Reference method" means any method of sampling and analyzing for an air pollutant as described in the following EPA regulations:

1. For ambient air quality standards in 9VAC5-30 (Ambient Air Quality Standards): The applicable appendix of 40 CFR Part 50 or any method that has been designated as a reference method in accordance with 40 CFR Part 53, except that it does not include a method for which a reference designation has been canceled in accordance with 40 CFR 53.11 or 40 CFR 53.16.

2. For emission standards in 9VAC5-40 (Existing Stationary Sources) and 9VAC5-50 (New and Modified

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Stationary Sources): Appendix M of 40 CFR Part 51 or Appendix A of 40 CFR Part 60.

3. For emission standards in 9VAC5-60 (Hazardous Air Pollutant Sources): Appendix B of 40 CFR Part 61 or Appendix A of 40 CFR Part 63.

"Regional director" means the regional director of an administrative region of the Department of Environmental Quality or a designated representative.

"Regulation of the board" means any regulation adopted by the State Air Pollution Control Board under any provision of the Code of Virginia.

"Regulations for the Control and Abatement of Air Pollution" means 9VAC5-10 (General Definitions) through 9VAC5-80 (Permits for Stationary Sources).

"Reid vapor pressure" means the absolute vapor pressure of volatile crude oil and volatile nonviscous petroleum liquids except liquefied petroleum gases as determined by American Society for Testing and Materials publication, "Standard Test Method for Vapor Pressure of Petroleum Products (Reid Method)" (see 9VAC5-20-21).

"Run" means the net period of time during which an emission sample is collected. Unless otherwise specified, a run may be either intermittent or continuous within the limits of good engineering practice.

"Section 111(d) plan" means the portion or portions of the plan, or the most recent revision thereof, which has been approved under 40 CFR 60.27(b) in accordance with § 111(d)(1) of the federal Clean Air Act, or promulgated under 40 CFR 60.27(d) in accordance with § 111(d)(2) of the federal Clean Air Act, and which implements the relevant requirements of the federal Clean Air Act.

"Section 111(d)/129 plan" means the portion or portions of the plan, or the most recent revision thereof, which has been approved under 40 CFR 60.27(b) in accordance with §§ 111(d)(1) and 129(b)(2) of the federal Clean Air Act, or promulgated under 40 CFR 60.27(d) in accordance with §§ 111(d)(2) and 129(b)(3) of the federal Clean Air Act, and which implements the relevant requirements of the federal Clean Air Act.

"Shutdown" means the cessation of operation of an affected facility for any purpose.

"Source" means any one or combination of the following: buildings, structures, facilities, installations, articles, machines, equipment, landcraft, watercraft, aircraft or other contrivances which contribute, or may contribute, either directly or indirectly to air pollution. Any activity by any person that contributes, or may contribute, either directly or indirectly to air pollution, including, but not limited to, open burning, generation of fugitive dust or emissions, and cleaning with abrasives or chemicals.

"Stack" means any point in a source designed to emit solids, liquids or gases into the air, including a pipe or duct, but not including flares.

"Stack in existence" means that the owner had:

1. Begun, or caused to begin, a continuous program of physical on site construction of the stack; or
2. Entered into binding agreements or contractual obligations, which could not be canceled or modified without substantial loss to the owner, to undertake a program of construction of the stack to be completed in a reasonable time.

"Standard conditions" means a temperature of 20°C (68°F) and a pressure of 760 mm of Hg (29.92 inches of Hg).

"Standard of performance" means any provision of 9VAC5-50 (New and Modified Stationary Sources) which prescribes an emissions limitation or other requirements that control air pollution emissions.

"Startup" means the setting in operation of an affected facility for any purpose.

"State enforceable" means all limitations and conditions which are enforceable by the board or department, including, but not limited to, those requirements developed pursuant to 9VAC5-170-160; requirements within any applicable regulation, order, consent agreement or variance; and any permit requirements established pursuant to 9VAC5-80 (Permits for Stationary Sources).

"State Implementation Plan" means the plan, including the most recent revision thereof, which has been approved or promulgated by the administrator, U.S. Environmental Protection Agency, under § 110 of the federal Clean Air Act, and which implements the requirements of § 110.

"Stationary source" means any building, structure, facility or installation which emits or may emit any air pollutant. A stationary source shall include all of the pollutant-emitting activities which belong to the same industrial grouping, are located on one or more contiguous or adjacent properties, and are under the control of the same person (or persons under common control) except the activities of any vessel. Pollutant-emitting activities shall be considered as part of the same industrial grouping if they belong to the same "Major Group" (i.e., which have the same two-digit code) as described in the Standard Industrial Classification Manual (see 9VAC5-20-21).

"These regulations" means 9VAC5-10 (General Definitions) through 9VAC5-80 (Permits for Stationary Sources).

"Total suspended particulate" or "TSP" means particulate matter as measured by the reference method described in Appendix B of 40 CFR Part 50.

"True vapor pressure" means the equilibrium partial pressure exerted by a petroleum liquid as determined in accordance with methods described in American Petroleum Institute (API) publication, "Evaporative Loss from External Floating-Roof Tanks" (see 9VAC5-20-21). The API procedure may not be applicable to some high viscosity or high pour crudes. Available estimates of true vapor pressure may be used in special cases such as these.

"Urban area" means any area consisting of a core city with a population of 50,000 or more plus any surrounding localities with a population density of 80 persons per square mile and designated as such in 9VAC5-20-201.

"Vapor pressure," except where specific test methods are specified, means true vapor pressure, whether measured directly, or determined from Reid vapor pressure by use of the applicable nomograph in American Petroleum Institute publication, "Evaporative Loss from Floating-Roof Tanks" (see 9VAC5-20-21).

"Virginia Air Pollution Control Law" means Chapter 13 (§ 10.1-1300 et seq.) of Title 10.1 of the Code of Virginia.

"Volatile organic compound" means any compound of carbon, excluding carbon monoxide, carbon dioxide, carbonic acid, metallic carbides or carbonates, and ammonium carbonate, which participates in atmospheric photochemical reactions.

1. This includes any such organic compounds which have been determined to have negligible photochemical reactivity other than the following:

- a. Methane;
- b. Ethane;
- c. Methylene chloride (dichloromethane);
- d. 1,1,1-trichloroethane (methyl chloroform);
- e. 1,1,2-trichloro-1,2,2-trifluoroethane (CFC-113);
- f. Trichlorofluoromethane (CFC-11);
- g. Dichlorodifluoromethane (CFC-12);
- h. Chlorodifluoromethane (HFC-22);
- i. Trifluoromethane (HFC-23);
- j. 1,2-dichloro 1,1,2,2-tetrafluoroethane (CFC-114);
- k. Chloropentafluoroethane (CFC-115);
- l. 1,1,1-trifluoro 2,2-dichloroethane (HCFC-123);
- m. 1,1,1,2-tetrafluoroethane (HFC-134a);
- n. 1,1-dichloro 1-fluoroethane (HCFC-141b);
- o. 1-chloro 1,1-difluoroethane (HCFC-142b);
- p. 2-chloro-1,1,1,2-tetrafluoroethane (HCFC-124);
- q. Pentafluoroethane (HFC-125);
- r. 1,1,2,2-tetrafluoroethane (HFC-134);
- s. 1,1,1-trifluoroethane (HFC-143a);
- t. 1,1-difluoroethane (HFC-152a);
- u. Parachlorobenzotrifluoride (PCBTF);
- v. Cyclic, branched, or linear completely methylated siloxanes;
- w. Acetone;
- x. Perchloroethylene (tetrachloroethylene);
- y. 3,3-dichloro-1,1,1,2,2-pentafluoropropane (HCFC-225ca);

- z. 1,3-dichloro-1,1,2,2,3-pentafluoropropane (HCFC-225cb);
- aa. 1,1,1,2,3,4,4,5,5,5-decafluoropentane (HFC 43-10mee);
- bb. Difluoromethane (HFC-32);
- cc. Ethylfluoride (HFC-161);
- dd. 1,1,1,3,3,3-hexafluoropropane (HFC-236fa);
- ee. 1,1,2,2,3-pentafluoropropane (HFC-245ca);
- ff. 1,1,2,3,3-pentafluoropropane (HFC-245ea);
- gg. 1,1,1,2,3-pentafluoropropane (HFC-245eb);
- hh. 1,1,1,3,3-pentafluoropropane (HFC-245fa);
- ii. 1,1,1,2,3,3-hexafluoropropane (HFC-236ea);
- jj. 1,1,1,3,3-pentafluorobutane (HFC-365mfc);
- kk. Chlorofluoromethane (HCFC-31);
- ll. 1 chloro-1-fluoroethane (HCFC-151a);
- mm. 1,2-dichloro-1,1,2-trifluoroethane (HCFC-123a);
- nn. 1,1,1,2,2,3,3,4,4-nonafluoro-4-methoxy-butane (C₄F₉OCH₃ or HFE-7100);
- oo. 2-(difluoromethoxymethyl)-1,1,1,2,3,3,3-heptafluoropropane ((CF₃)₂CF₂OCH₃);
- pp. 1-ethoxy-1,1,2,2,3,3,4,4,4-nonafluorobutane (C₄F₉OC₂H₅ or HFE-7200);
- qq. 2-(ethoxydifluoromethyl)-1,1,1,2,3,3,3-heptafluoropropane ((CF₃)₂CF₂OC₂H₅);
- rr. Methyl acetate; ss. 1,1,1,2,2,3,3-heptafluoro-3-methoxy-propane (n-C₃F₇OCH₃) (HFE-7000);
- tt. 3-ethoxy-1,1,1,2,3,4,4,5,5,6,6,6-dodecafluoro-2-(trifluoromethyl) hexane (HFE-7500);
- uu. 1,1,1,2,3,3,3-heptafluoropropane (HFC 227ea);
- vv. methyl formate (HCOOCH₃);
- ww. 1,1,1,2,2,3,4,5,5,5-decafluoro-3-methoxy-4-trifluoromethyl-pentane (HFE-7300);
- xx. propylene carbonate;
- yy. dimethyl carbonate;
- zz. trans-1,3,3,3-tetrafluoropropene; and
- aaa. HCF₂OCF₂H (HFE-134);
- bbb. HCF₂OCF₂OCF₂H (HFE-236cal2);
- ccc. HCF₂OCF₂CF₂OCF₂H (HFE-338pcc13);
- ddd. HCF₂OCF₂OCF₂CF₂OCF₂H (H-Galden 1040x or H-Galden ZT 130 (or 150 or 180)); ~~and~~
- eee. trans 1-chloro-3,3,3-trifluoroprop-1-ene;
- fff. 2,3,3,3-tetrafluoropropene; and
- ggg. Perfluorocarbon compounds which fall into these classes:
 - (1) Cyclic, branched, or linear, completely fluorinated alkanes;

- (2) Cyclic, branched, or linear, completely fluorinated ethers with no unsaturations;
- (3) Cyclic, branched, or linear, completely fluorinated tertiary amines with no unsaturations; and
- (4) Sulfur containing perfluorocarbons with no unsaturations and with sulfur bonds only to carbon and fluorine.

2. For purposes of determining compliance with emissions standards, volatile organic compounds shall be measured by the appropriate reference method in accordance with the provisions of 9VAC5-40-30 or 9VAC5-50-30, as applicable. Where such a method also measures compounds with negligible photochemical reactivity, these negligibly reactive compounds may be excluded as a volatile organic compound if the amount of such compounds is accurately quantified, and such exclusion is approved by the board.

3. As a precondition to excluding these compounds as volatile organic compounds or at any time thereafter, the board may require an owner to provide monitoring or testing methods and results demonstrating, to the satisfaction of the board, the amount of negligibly reactive compounds in the emissions of the source.

4. Exclusion of the above compounds in this definition in effect exempts such compounds from the provisions of emission standards for volatile organic compounds. The compounds are exempted on the basis of being so inactive that they will not contribute significantly to the formation of ozone in the troposphere. However, this exemption does not extend to other properties of the exempted compounds which, at some future date, may require regulation and limitation of their use in accordance with requirements of the federal Clean Air Act.

5. The following compound is a VOC for purposes of all recordkeeping, emissions reporting, photochemical dispersion modeling and inventory requirements that apply to VOCs and shall be uniquely identified in emission reports, but is not a VOC for purposes of VOC emission standards, VOC emissions limitations, or VOC content requirements: t-butyl acetate.

"Welfare" means that language referring to effects on welfare includes, but is not limited to, effects on soils, water, crops, vegetation, man-made materials, animals, wildlife, weather, visibility and climate, damage to and deterioration of property, and hazards to transportation, as well as effects on economic values and on personal comfort and well-being.

VA.R. Doc. No. R15-3855; Filed December 24, 2014, 9:32 a.m.

TITLE 12. HEALTH

STATE BOARD OF HEALTH

Emergency Regulation

Titles of Regulations: **12VAC5-71. Regulations Governing Virginia Newborn Screening Services (amending 12VAC5-71-30, 12VAC5-71-150; adding 12VAC5-71-200 through 12VAC5-71-260).**

12VAC5-191. State Plan for the Children with Special Health Care Needs Program (amending 12VAC5-191-260).

Statutory Authority: §§ 32.1-12, 32.1-65.1, and 32.1-67 of the Code of Virginia.

Effective Dates: December 24, 2014, through June 23, 2016.

Agency Contact: Dev Nair, Director, Division of Policy and Evaluation, Department of Health, 109 Governor Street, Richmond, VA 23219, telephone (804) 864-7662, FAX (804) 864-7647, or email dev.nair@vdh.virginia.gov.

Preamble:

Congenital heart defects are the most common birth defects in the United States, affecting about one in every 110 babies. A few babies born with congenital heart defects have more serious forms of heart disease, critical congenital heart disease (CCHD). CCHDs are heart defects that result in abnormal blood flow and oxygen deprivation. These defects require intervention within the first year of life, and delayed diagnosis can result in death. Screening newborns for CCHD using pulse oximetry has been recommended through the U.S. Department of Health and Human Services Secretary's Recommended Uniform Screening Panel. The screening is simple, quick, and painless. A sensor wrapped around the baby's right hand or either foot measures the amount of oxygen in the baby's blood.

Most Virginia hospitals already provide CCHD screening voluntarily. These regulations require a small number of additional hospitals to implement the screening. The regulations also permit the Virginia Department of Health (VDH) to collect information via the Virginia Congenital Anomalies Reporting and Education System (VaCARES) reporting system so that infants identified with a critical congenital heart disease can be referred to the Care Connection for Children network to obtain care coordination services.

Chapters 4 and 175 of the 2014 Acts of Assembly require VDH to implement regulations relating to screening for CCHD. The legislation requires VDH to promulgate regulations within 280 days of enactment. Pursuant to the legislation, the regulations include provisions to implement CCHD screening for all babies born in hospitals with newborn nurseries. The legislation also requires VDH to

convene a workgroup to provide information and recommendations for the development of the regulations.

12VAC5-71-30. Core panel of heritable disorders and genetic diseases.

A. The Virginia Newborn Screening System, which includes the Virginia Newborn Screening Program and the Virginia Early Hearing Detection and Intervention Program, and Virginia critical congenital heart disease screening, shall ensure that the core panel of heritable disorders and genetic diseases for which newborn screening is conducted is consistent with but not necessarily identical to the U.S. Department of Health and Human Services Secretary's Recommended Uniform Screening Panel.

B. The department shall review, at least biennially, national recommendations and guidelines and may propose changes to the core panel of heritable disorders and genetic diseases for which newborn dried-blood-spot screening tests are conducted.

C. The Virginia Genetics Advisory Committee may be consulted and provide advice to the commissioner on proposed changes to the core panel of heritable disorders and genetic diseases for which newborn dried-blood-spot screening tests are conducted.

D. Infants under six months of age who are born in Virginia shall be screened in accordance with the provisions set forth in this chapter for the following heritable disorders and genetic diseases, which are identified through newborn dried-blood-spot screening tests:

1. Argininosuccinic aciduria (ASA);
2. Beta-Ketothiolase deficiency (BKT);
3. Biotinidase deficiency (BIOT);
4. Carnitine uptake defect (CUD);
5. Classical galactosemia (galactose-1-phosphate uridylyltransferase deficiency) (GALT);
6. Citrullinemia type I (CIT-I);
7. Congenital adrenal hyperplasia (CAH);
8. Cystic fibrosis (CF);
9. Glutaric acidemia type I (GA I);
10. Hb S beta-thalassemia (Hb F,S,A);
11. Hb SC-disease (Hb F,S,C);
12. Hb SS-disease (sickle cell anemia) (Hb F, S);
13. Homocystinuria (HCY);
14. Isovaleric acidemia (IVA);
15. Long chain L-3-Hydroxy acyl-CoA dehydrogenase deficiency (LCHAD);
16. Maple syrup urine disease (MSUD);
17. Medium-chain acyl-CoA dehydrogenase deficiency (MCAD);
18. Methylmalonic acidemia (Methylmalonyl-CoA mutase deficiency) (MUT);

19. Methylmalonic acidemia (Adenosylcobalamin synthesis deficiency) (CBL A, CBL B);
20. Multiple carboxylase deficiency (MCD);
21. Phenylketonuria (PKU);
22. Primary congenital hypothyroidism (CH);
23. Propionic acidemia (PROP);
24. Tyrosinemia type I (TYR I);
25. Trifunctional protein deficiency (TFP);
26. Very long-chain acyl-CoA dehydrogenase deficiency (VLCAD);
27. 3-hydroxy 3-methyl glutaric aciduria (HMG); and
28. 3-Methylcrotonyl-CoA carboxylase deficiency (3-MCC).

E. Infants born in Virginia shall be screened for hearing loss in accordance with provisions set forth in §§ 32.1-64.1 and 32.1-64.2 of the Code of Virginia and as governed by 12VAC5-80.

F. Newborns born in Virginia shall be screened for critical congenital heart disease in accordance with provisions set forth in §§ 32.1-65.1 and 32.1-67 of the Code of Virginia and as governed by 12VAC5-71-200 through 12VAC5-71-260.

12VAC5-71-150. Responsibilities of the Care Connection for Children network.

A. The Care Connection for Children network shall provide the following services:

1. Care coordination services for residents of the Commonwealth who are diagnosed with selected heritable disorders ~~or~~, genetic diseases, or critical congenital heart disease and are referred to the network by the Virginia Newborn Screening Program.
2. Other network services for eligible individuals in accordance with ~~the~~ § 32.1-77 of the Code of Virginia and applicable regulations.

B. The Care Connection for Children network shall provide data as needed by the department's newborn screening program.

12VAC5-71-200. Definitions related to critical congenital heart disease screening.

As used in the following sections relating to critical congenital heart disease screening, the following words and terms shall have the following meanings unless the context clearly indicates otherwise:

"Abnormal screening results" means all results that indicate the newborn has not passed the screening test.

"Critical congenital heart disease" or "CCHD" means a congenital heart disease that places a newborn at significant risk of disability or death if not diagnosed and treated soon after birth. The disease may include, but is not limited to hypoplastic left heart syndrome, pulmonary atresia (with intact septum), tetralogy of fallot, total anomalous pulmonary

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venous return, transposition of the great arteries, tricuspid atresia, and truncus arteriosus.

"CCHD screening" means the application of screening technology to detect CCHD.

"Echocardiogram" means a test that uses an ultrasound to provide an image of the heart.

"Licensed practitioner" means a licensed health care provider who is permitted, within the scope of his practice pursuant to Chapter 29 (§ 54.1-2900 et seq.) or Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia to provide care to a newborn.

"Newborn" means a person in the first 28 days of life who was born in Virginia or on federal property within Virginia.

"Newborn nursery" means a general level, intermediate level, or specialty level newborn service as defined in 12VAC5-410-443 B 1, B 2, and B 3.

"Screening technology" means pulse oximetry testing in the right hand and either foot. Screening technology shall also include alternate medically accepted tests that measure the percentage of blood oxygen saturation, follow medical guideline consensus and recommendations issued by the American Academy of Pediatrics, and are approved by the State Board of Health.

"Specialty level nursery" means the same as defined in 12VAC5-410-443 B 3 and as further defined as Level III Neonatal Care by the Guidelines for Perinatal Care (7th edition) written by the American Academy of Pediatrics and the American College of Obstetrics and Gynecology.

"Subspecialty level nursery" means the same as defined in 12VAC5-410-443 B 4.

12VAC5-71-210. Critical congenital heart disease screening protocols.

A. Hospitals shall develop protocols for critical congenital heart disease screening in accordance with 12VAC5-71-200 through 12VAC5-72-260 and national recommendations from the American Academy of Pediatrics.

B. Hospitals shall develop protocols for the physical evaluation by licensed practitioners of newborns with abnormal screening results.

C. Hospitals shall develop protocols for the referral of newborns with abnormal screening results, if needed, after evaluation.

12VAC5-71-220. Critical congenital heart disease screening.

A. A licensed practitioner shall perform the screening.

B. Except as specified in subsection C of this section and 12VAC5-71-260, CCHD screening shall be performed on every newborn in the birth hospital between 24 and 48 hours of life, or if the newborn is discharged from the hospital before reaching 24 hours of life, the CCHD screening shall be performed as late as practical before discharge.

C. If CCHD screening is not indicated, the reason shall be documented in the newborn's medical record. The reasons include but are not limited to:

1. The newborn's current clinical evaluation has included an echocardiogram that ruled out CCHD;
2. The newborn has confirmed CCHD; or
3. The newborn was premature and is still under the care of a specialty level or subspecialty level nursery.

D. Hospitals shall develop protocols for screening newborns in specialty level and subspecialty level nurseries in accordance with national recommendations from the American Academy of Pediatrics.

12VAC5-71-230. Critical congenital heart disease screening results.

A. Recording results.

1. All CCHD screening results shall be recorded in the newborn's medical record.
2. All CCHD screening results shall be entered into the electronic birth certificate system with the following information:
 - a. CCHD screening completed; and
 - b. CCHD pass or fail.

B. Abnormal screening results.

1. Abnormal screening results shall be reported by the authorized health care provider who conducted the screening to the attending physician or his designee as soon as the result is obtained.
2. A newborn shall be evaluated by an attending physician or his designee according to the timeframes within the hospital protocol developed in accordance with 12VAC5-71-210 B to complete the protocol recommended by the American Academy of Pediatrics.
3. A newborn shall not be discharged from care until:
 - a. A cause for the abnormal screening result has been determined and a plan is in place for immediate evaluation at another medical facility; or
 - b. An echocardiogram has been performed and read and an appropriate clinical plan has been developed.
4. Any diagnosis arising from abnormal screening results shall be entered into the electronic birth certificate system.
5. The attending physician or his designee shall provide notification of abnormal results and any diagnoses to the newborn's parent or guardian and to the primary care provider in charge of the newborn's care after the newborn leaves the hospital.

12VAC5-71-240. Referral for care coordination.

A. For any person diagnosed under these regulations, the chief administrative officer of every hospital, as defined in § 32.1-123 of the Code of Virginia, shall make or cause to be

made a report to the commissioner in accordance with § 32.1-69.1 of the Code of Virginia.

B. Upon receiving the notification described in subsection A of this section, the Newborn Screening Program at the Virginia Department of Health shall refer the newborn's parent or guardian to the Care Connection for Children network for care coordination services.

12VAC5-71-250. Congenital heart disease screening records.

A. The screening of newborns pursuant to this chapter is a population-based public health surveillance program as defined by the Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191; 110 Stat. 2033).

B. Upon request, a hospital shall make available to the Virginia Congenital Anomalies Reporting and Education System (VaCARES):

1. Medical records;
2. Records of laboratory tests; and
3. Any other information that VaCARES considers necessary to:
 - a. Determine final outcomes of abnormal CCHD screening results; or
 - b. Evaluate CCHD screening activities in the Commonwealth, including performance of follow-up evaluations and diagnostic tests, initiation of treatment when necessary, and surveillance of the accuracy and efficacy of the screening.

C. Information that the Virginia Department of Health receives under this section is confidential and may only be used or disclosed:

1. For research and collective statistical purposes, pursuant to § 32.1-67.1 of the Code of Virginia;
2. For state or federally mandated statistical reports;
3. To ensure that the information received by the Virginia Department of Health is accurate and reliable; or
4. For reporting to the Virginia Congenital Anomalies Reporting and Education System pursuant to § 32.1-69.1 of the Code of Virginia and 12VAC5-191-280. The Newborn Screening Program shall refer the newborn's parent or guardian to the Care Connection for Children network for care coordination services.

D. The hospital administrator shall ensure that CCHD screening is included in the perinatal quality assurance program and provide the results of the quality improvement program to the Virginia Department of Health upon request.

12VAC5-71-260. Parent or guardian refusal for screening.

A. In the instance of parent or guardian refusal of the CCHD screening based on religious practices or tenets, the parent or guardian refusal shall be documented on a refusal form

provided by the Virginia Department of Health and made a part of the newborn's medical record.

B. The administrator of the hospital shall ensure that the Newborn Screening Program at the Virginia Department of Health is notified in writing of the parent or guardian refusal within five days of the newborn's birth.

NOTICE: The following forms used in administering the regulation were filed by the agency. The forms are not being published; however, online users of this issue of the Virginia Register of Regulations may click on the name of a form with a hyperlink to access it. The forms are also available from the agency contact or may be viewed at the Office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Richmond, Virginia 23219.

FORMS (12VAC5-71)

[Notification of Parental Refusal of Dried-Blood-Spot and Critical Congenital Heart Disease Screening \(undated\)](#)

12VAC5-191-260. Scope and content of the Virginia Newborn Screening System.

A. The Virginia Newborn Screening System consists of ~~two~~ three components: (i) Virginia Newborn Screening Services ~~and~~, (ii) Virginia Early Hearing Detection and Intervention Program, and (iii) Virginia critical congenital heart disease screening.

B. Virginia Newborn Screening Services.

1. Mission. The Virginia Newborn Screening Services prevents ~~mental retardation~~ intellectual disability, permanent disability, or death through early identification and treatment of infants who are affected by selected inherited disorders.

2. Scope of services. The Virginia Newborn Screening Services provides a coordinated and comprehensive system of services to assure that all infants receive a screening test after birth for selected inherited metabolic, endocrine, and hematological disorders as defined in Regulations Governing the Newborn Screening and Treatment Program, ~~12VAC5-70~~ 12VAC5-71.

These population-based, direct, and enabling services are provided through:

- a. Biochemical dried bloodspot screening tests.
- b. Follow up of abnormal results.
- c. Diagnosis.
- d. Education to health professionals and families.
- e. Expert consultation on abnormal results, diagnostic testing, and medical and dietary management for health professionals.

Medical and dietary management is provided for the diagnosed cases and includes assistance in accessing specialty medical services and referral to Care Connection for Children.

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The screening and management for specified diseases are governed by Regulations Governing ~~the Virginia Newborn Screening and Treatment Program Services~~, 12VAC5-70 12VAC5-71.

3. Criteria to receive Virginia Newborn Screening Services. All infants born in the Commonwealth are eligible for the screening test for selected inherited disorders.

4. Goal. The Title V national performance measures, as required by the federal Government Performance and Results Act (GPRA-Pub. L. 103-62), are used to establish the program goals. The following goal shall change as needed to be consistent with the Title V national performance measures:

All infants will receive appropriate newborn bloodspot screening, follow up testing, and referral to services.

C. Virginia Early Hearing Detection and Intervention Program.

1. Mission. The Virginia Early Hearing Detection and Intervention Program promotes early detection of and intervention for infants with congenital hearing loss to maximize linguistic and communicative competence and literacy development.

2. Scope of services. The Virginia Early Hearing Detection and Intervention Program provides services to assure that all infants receive a hearing screening after birth, that infants needing further testing are referred to appropriate facilities, that families have the information that they need to make decisions for their children, and that infants and young children diagnosed with a hearing loss receive appropriate and timely intervention services. These population-based and enabling services are provided through:

- a. Technical assistance and education to new parents.
- b. Collaboration with physicians and primary care providers.
- c. Technical assistance and education to birthing facilities and those persons performing home births.
- d. Collaboration with audiologists.
- e. Education to health professionals and general public.

Once diagnosed, the infants are referred to early intervention services. The screening and management for hearing loss are governed by the regulation, Regulations for Administration of the Virginia Hearing Impairment Identification and Monitoring System, 12VAC5-80.

3. Criteria to receive services from the Virginia Early Hearing Detection and Intervention Program.

- a. All infants born in the Commonwealth are eligible for the hearing screening.
- b. All infants who are residents of the Commonwealth and their families are eligible for the Virginia Early Hearing Detection and Intervention Program.

4. Goals. The Title V national performance measures, as required by the federal Government Performance and Results Act (GPRA-Pub. L. 103-62), are used to establish the program goals. The following goals shall change as needed to be consistent with the Title V national performance measures:

All infants will receive screening for hearing loss no later than one month of age, achieve identification of congenital hearing loss by three months of age, and enroll in appropriate intervention by six months of age.

D. Virginia critical congenital heart disease screening.

1. Mission. Virginia critical congenital heart disease screening promotes early detection of and intervention for newborns with critical congenital heart disease to maximize positive health outcomes and help prevent disability and death early in life.

2. Scope of services. Newborns receive a critical congenital heart disease screening 24 to 48 hours after birth in a hospital with a newborn nursery, as provided in §§ 32.1-67 and 32.1-69.1 of the Code of Virginia and the regulations governing critical congenital heart disease screening (12VAC5-71-200 through 12VAC5-71-260). These population-based, direct, and enabling services are provided through:

- a. Critical congenital heart disease screening tests using pulse oximetry or other screening technology as defined in 12VAC5-71-200;
- b. Hospital reporting of test results pursuant to § 32.1-69.1 of the Code of Virginia and 12VAC5-191-280; and
- c. Follow-up, referral processes, and services, as appropriate, through Care Connection for Children.

3. The screening and management for newborn critical congenital heart disease are governed by the regulations governing critical congenital heart disease screening (12VAC5-71-200 through 12VAC5-71-260).

4. Criteria to receive critical congenital heart disease screening. Except as specified in 12VAC5-71-220 C and 12VAC5-71-260, all newborns born in the Commonwealth in a hospital with a newborn nursery shall receive the screening test for critical congenital heart disease 24 to 48 hours after birth using pulse oximetry or other screening technology.

5. Goal. Except as specified in 12VAC5-71-220 C and 12VAC5-71-260, all newborns born in the Commonwealth in a hospital with a newborn nursery shall receive appropriate critical congenital heart disease screening 24 to 48 hours after birth.

VA.R. Doc. No. R15-4176; Filed December 24, 2014, 10:13 a.m.

**DEPARTMENT OF MEDICAL ASSISTANCE
SERVICES**

Emergency Regulation

Title of Regulation: 12VAC30-120. Waivered Services (amending 12VAC30-120-360 through 12VAC30-120-395, 12VAC30-120-410, 12VAC30-120-420).

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

Effective Dates: January 1, 2015, through June 30, 2016.

Agency Contact: Victoria Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-6043, FAX (804) 786-1680, TTY (800) 343-0634, or email victoria.simmons@dmas.virginia.gov.

Preamble:

Section 2.2-4011 B 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 N of Chapter 2 of the 2014 Acts of Assembly provides the Department of Medical Assistance Services the authority to:

- 1. Seek federal approval of changes to its MEDALLION waiver and its Medallion II waiver.*
- 2. Conform the state regulations to the federally approved changes and, in order to implement the provisions of the act, to promulgate emergency regulations and to implement the necessary regulatory changes to be consistent with federal approval of the waiver changes.*

DMAS sought federal approval of changes to this § 1915(b) of the Social Security Act waiver and received approval dated July 14, 2014, from the Centers for Medicare & Medicaid Services. The amendments to the regulations conform to the federally approved waiver changes.

This emergency regulatory action implements several mandates from various legislative actions to (i) require individuals who are participating in a home and community-based care services waiver, specifically the Elderly or Disabled with Consumer Direction Waiver, to also be enrolled in Medicaid contracted managed care organizations and (ii) require expedited enrollment for Medicaid individuals into Medicaid contracted managed care organizations, especially for pregnant women.

Medallion II, a mandatory managed care organization (MCO) program, expanded throughout the Commonwealth the use of managed care for the delivery of health care to Medicaid recipients. Medallion II was created for the purposes of further improving access to care, promoting disease prevention, ensuring quality care, and reducing

Medicaid expenditures. The program requires mandatory enrollment into a contracted MCO for certain specified groups of Medicaid recipients. Also, certain specified groups of individuals are excluded from managed care enrollment. MCOs have provided the Commonwealth with the most value per taxpayer dollar for the provision of high quality health care and provide an integrated, comprehensive delivery system to individuals enrolled in Medicaid. 12VAC30-120-360 through 12VAC30-120-420 were promulgated to implement this program.

Currently, the managed care health plans provide acute care coverage for approximately 4,600 home and community-based waiver participants through the Acute and Long Term Care (ALTC) Phase I program. This includes individuals enrolled in the Elderly or Disabled with Consumer Direction Waiver, the Intellectual Disability Waiver, the Individuals and Family Developmental Disabilities Support Waiver, the Day Support Waiver, and the Alzheimer's Assisted Living Waiver. Under the Phase I program, if an MCO enrolled Medicaid member subsequently becomes eligible for and enrolled into one of five home and community-based waivers, then he remains enrolled with the MCO for primary and acute care services while all long-term care services, such as personal care, respite care, personal emergency response systems, and environmental modifications, are covered under the fee-for-service reimbursement system.

Item 297 MMM 1 of the 2011 Appropriation Act directed the department to "seek federal authority through amendments to the State Plan under Title XIX of the Social Security Act, and any necessary waivers, to allow individuals enrolled in Home and Community Based Care (HCBC) waivers to also be enrolled in contracted Medallion II managed care organizations for the purposes of receiving acute and medical care services." Effective December 1, 2014, the department launched the Health and Acute Care Program (HAP). This initiative allows eligible HCBC waiver enrollees to receive their acute and primary medical care through one of the managed care health plans and, concurrently, the individual's HCBC waiver services, including transportation to the waived services, are paid through the Medicaid fee-for-service system as a "carved out" service. These individuals will be participating concurrently in both § 1915(b) and § 1915(c) waivers. As part of the HAP initiative, approximately 2,700 individuals enrolled in the Elderly or Disabled with Consumer Direction Waiver who currently receive acute medical services in the fee-for-service program and who are eligible for managed care (i.e., do not have any managed care exclusions) will be transitioned into managed care in December. The ALTC program will be rebranded as HAP.

Item 307 FFF of the 2012 Appropriation Act authorized the department to seek federal authority through

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amendments to the State Plan under Title XIX and XXI of the Social Security Act, and appropriate waivers to such, to develop and implement programmatic and system changes that allow expedited enrollment of Medicaid eligible recipients into Medicaid managed care, most importantly for pregnant women. In an effort to ensure that newly eligible Medicaid individuals, especially pregnant women, have quicker access to the managed care delivery system, the department will shorten the period of time between an individual being identified as Medicaid eligible and that individual's enrollment into an MCO. DMAS anticipates that this new process will reduce disruptions of continuity of care by minimizing the movement of individuals between the fee-for-service and the managed care delivery systems.

Part VI

~~Medallion II~~ Mandatory Managed Care

12VAC30-120-360. Definitions.

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

"Action" means the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the state; or the failure of an MCO to act within the timeframes provided in 42 CFR 438.408(b).

"Appeal" means a request for review of an action, as "action" is defined in this section.

"Area of residence" means the individual's address in the Medicaid eligibility file.

"Capitation payment" means a payment the department makes periodically to a contractor on behalf of each individual enrolled under a contract for the provision of medical services under the State Plan, regardless of whether the particular individual receives services during the period covered by the payment.

"Covered services" means Medicaid services as defined in the State Plan for Medical Assistance.

"Disenrollment" means the process of changing enrollment from one ~~Medallion II~~ Managed Care Organization (MCO) plan to another MCO, if applicable.

"DMAS" means the Department of Medical Assistance Services.

~~"Enrollee" or "enrollees" means people having current Medicaid eligibility who shall be in the process of being authorized by DMAS to be enrolled in Medallion II.~~

"Early Intervention" means EPSDT Early Intervention services provided pursuant to Part C of the Individuals with Disabilities Education Act (IDEA) of 2004 as set forth in 12VAC30-50-131.

"Eligible person" means any person eligible for Virginia Medicaid in accordance with the State Plan for Medical Assistance under Title XIX of the Social Security Act.

"Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
2. Serious impairment to bodily functions, or
3. Serious dysfunction of any bodily organ or part.

"Emergency services" means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services and that are needed to evaluate or stabilize an emergency medical condition.

"Enrollee," "enrollees," "member," or "members" means a person or persons who are eligible for Medicaid, who have undergone enrollment for mandatory managed care, and who are currently enrolled in a mandatory managed care organization.

"Enrollment broker" means an independent contractor that enrolls individuals in the contractor's plan and is responsible for the operation and documentation of a toll-free individual service helpline. The responsibilities of the enrollment broker include, but shall not be limited to, individual education and MCO enrollment, assistance with and tracking of individuals' complaints resolutions, and may include individual marketing and outreach.

"Exclusion from ~~Medallion II~~ mandatory managed care" means the removal of an enrollee from the ~~Medallion II~~ mandatory managed care program on a temporary or permanent basis.

"External quality review organization" or "EQRO" means an organization that meets the competence and independence requirements set forth in 42 CFR 438.354 and performs external quality reviews, other external quality review related activities as set forth in 42 CFR 438.358, or both.

"Grievance" means an expression of dissatisfaction about any matter other than an action, as "action" is defined in this section.

"Health care plan" means any arrangement in which any managed care organization undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services.

"Health care professional" means a provider as defined in 42 CFR 438.2.

"Individual" or "individuals" means ~~people~~ a person or persons who are eligible for Medicaid ~~but~~, who are not yet undergoing enrollment ~~nor~~ for mandatory managed care, and

who are not enrolled in a mandatory managed care organization.

"Managed care organization" or "MCO" means an entity that meets the participation and solvency criteria defined in 42 CFR Part 438 and has an executed contractual agreement with DMAS to provide services covered under the ~~Medallion II~~ mandatory managed care program. Covered services for ~~Medallion II~~ mandatory managed care program individuals ~~must~~ shall be as accessible (in terms of timeliness, amount, duration, and scope) as compared to other Medicaid individuals served within the geographic area.

~~"Member" or "members" means people who have current Medicaid eligibility who are also enrolled in Medallion II managed care.~~

"Network" means doctors, hospitals or other health care providers who participate or contract with an MCO contractor and, as a result, agree to accept a mutually-agreed upon sum or fee schedule as payment in full for covered services that are rendered to eligible participants.

"Newborn enrollment period" means the period from the child's date of birth plus the next two calendar months.

"Nonparticipating provider" means a health care entity or health care professional not in the contractor's participating provider network.

~~"Participant" or "participants" means an individual or individuals having current Medicaid eligibility who shall be authorized by DMAS to be a member or members of Medallion II.~~

"PCP of record" means a primary care physician of record with whom the recipient has an established history and such history is documented in the individual's records.

"Post-stabilization care services" means covered services related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition or to improve or resolve the enrollee's condition.

~~"Potential enrollee" means a Medicaid individual who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific MCO or "potential enrollees" means a person or persons who are eligible for Medicaid, who are undergoing enrollment for mandatory managed care, but who are not yet enrolled in a mandatory managed care organization.~~

"Retractions" means the departure of an enrolled managed care organization from any one or more localities as provided for in 12VAC30-120-370.

"Rural exception" means a rural area designated in the § 1915(b) managed care waiver, pursuant to § 1932(a)(3)(B) of the Social Security Act and 42 CFR § 438.52(b) and recognized by the Centers for Medicare and Medicaid Services, wherein qualifying ~~Medallion II~~ mandatory

managed care members are mandated to enroll in the one available contracted MCO.

"School health services" means those physical therapy, occupational therapy, speech therapy, nursing, psychiatric and psychological services rendered to children who qualify for these services under the federal Individuals with Disabilities Education Act (20 USC § 1471 et seq.) by (i) employees of the school divisions or (ii) providers that subcontract with school divisions, as described in 12VAC30-50-130.

"Spend-down" means the process of reducing countable income by deducting incurred medical expenses for medically needy individuals, as determined in the State Plan for Medical Assistance.

12VAC30-120-370. ~~Medallion II~~ Managed care enrollees.

A. DMAS shall determine enrollment in ~~Medallion II~~ mandatory managed care. Medicaid eligible persons not meeting the exclusion criteria set out in this section ~~must~~ shall participate in the ~~Medallion II~~ mandatory managed care program. Enrollment in ~~Medallion II~~ mandatory managed care ~~shall~~ not be a guarantee of continuing eligibility for services and benefits under the Virginia Medical Assistance Services Program.

1. DMAS reserves the right to exclude from participation in the ~~Medallion II~~ mandatory managed care program any member who has been consistently noncompliant with the policies and procedures of managed care or who is threatening to providers, MCOs, or DMAS. There must be sufficient documentation from various providers, the MCO, and DMAS of these noncompliance issues and any attempts at resolution. Members excluded from ~~Medallion II~~ mandatory managed care through this provision may appeal the decision to DMAS.

2. Individuals enrolled in the Elderly or Disabled with Consumer Direction waiver pursuant to Part IX (12VAC30-120-900 et seq.) of 12VAC30-120 shall be required to enroll in managed care.

B. The following individuals shall be excluded (as defined in 12VAC30-120-360) from participating in ~~Medallion II~~ mandatory managed care as defined in the § 1915(b) managed care waiver. Individuals excluded from ~~Medallion II~~ mandatory managed care shall include the following:

1. Individuals who are inpatients in state mental hospitals;
2. Individuals who are approved by DMAS as inpatients in long-stay hospitals, nursing facilities, or intermediate care facilities for individuals with intellectual disabilities;
3. Individuals who are placed on spend-down;
4. Individuals who are participating in the family planning waiver, or in federal waiver programs for home-based and community-based Medicaid coverage prior to managed care enrollment;

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5. Individuals under age 21 who are approved for DMAS residential facility Level C programs as defined in 12VAC30-130-860;

6. Newly eligible individuals who are in the third trimester of pregnancy and who request exclusion within a department-specified timeframe of the effective date of their MCO enrollment. Exclusion may be granted only if the member's obstetrical provider (~~e.g.~~ i.e., physician, hospital, or midwife) does not participate with the enrollee's assigned MCO. Exclusion requests made during the third trimester may be made by the member, MCO, or provider. DMAS shall determine if the request meets the criteria for exclusion. Following the end of the pregnancy, these individuals shall be required to enroll to the extent they remain eligible for Medicaid;

7. Individuals, other than students, who permanently live outside their area of residence for greater than 60 consecutive days except those individuals placed there for medically necessary services funded by the MCO;

8. Individuals who receive hospice services in accordance with DMAS criteria;

9. Individuals with other comprehensive group or individual health insurance coverage, including Medicare, insurance provided to military dependents, and any other insurance purchased through the Health Insurance Premium Payment Program (HIPP);

10. Individuals requesting exclusion who are inpatients in hospitals, other than those listed in subdivisions 1 and 2 of this subsection, at the scheduled time of MCO enrollment or who are scheduled for inpatient hospital stay or surgery within 30 calendar days of the MCO enrollment effective date. The exclusion shall remain effective until the first day of the month following discharge. This exclusion reason shall not apply to members admitted to the hospital while already enrolled in a department-contracted MCO;

11. Individuals who request exclusion during ~~preassignment~~ assignment to an MCO or within a time set by DMAS from the effective date of their MCO enrollment, who have been diagnosed with a terminal condition and who have a life expectancy of six months or less. The ~~client's~~ individual's physician must certify the life expectancy;

12. Certain individuals between birth and age three certified by the Department of Behavioral Health and Developmental Services as eligible for services pursuant to Part C of the Individuals with Disabilities Education Act (20 USC § 1471 et seq.) who are granted an exception by DMAS to the mandatory ~~Medallion-H~~ managed care enrollment;

13. Individuals who have an eligibility period that is less than three months;

14. Individuals who are enrolled in the Commonwealth's Title XXI SCHIP program;

15. Individuals who have an eligibility period that is only retroactive; and

16. Children enrolled in the Virginia Birth-Related Neurological Injury Compensation Program established pursuant to Chapter 50 (§ 38.2-5000 et seq.) of Title 38.2 of the Code of Virginia.

C. Members enrolled with a MCO who subsequently meet one or more of the criteria of ~~subsections A and~~ subsection B of this section during MCO enrollment shall be excluded from MCO participation as determined by DMAS, with the exception of those who subsequently become participants in the federal long-term care waiver programs, as otherwise defined elsewhere in this chapter, for home-based and community-based Medicaid coverage (~~AIDS,~~ IFDDS, ~~MR/ID ID,~~ EDCD, Day Support, or Alzheimer's, or as may be amended from time to time). These individuals shall receive acute and primary medical services via the MCO and shall receive waiver services and related transportation to waiver services via the fee-for-service program.

Individuals excluded from mandatory managed care enrollment shall receive Medicaid services under the current fee-for-service system. When individuals no longer meet the criteria for exclusion, they shall be required to enroll in the appropriate managed care program.

D. Individuals who are enrolled in localities that qualify for the rural exception may meet exclusion criteria if their PCP of record, as defined in 12VAC30-120-360, cannot or will not participate with the one MCO in the locality. Individual requests to be excluded from MCO participation in localities meeting the qualification for the rural exception must be made to DMAS for consideration on a case-by-case basis. ~~Recipients~~ Members enrolled in MCO rural exception areas shall not have open enrollment periods and shall not be afforded the 90-day window after initial enrollment during which they may make a health plan or program change.

Individuals excluded from mandatory managed care enrollment shall receive Medicaid services under the current fee-for-service system. When individuals no longer meet the criteria for exclusion, they shall be required to enroll in the appropriate managed care program.

E. ~~Medallion-H~~ Mandatory managed care plans shall be offered to individuals, and individuals shall be enrolled in those plans, exclusively through an independent enrollment broker under contract to DMAS.

F. ~~Clients~~ Members shall be enrolled as follows:

1. All eligible individuals, except those meeting one of the exclusions of subsection B of this section, shall be enrolled in ~~Medallion-H~~ mandatory managed care.

2. Individuals shall receive a Medicaid card from DMAS, and shall be provided authorized medical care in accordance with DMAS' procedures after Medicaid eligibility has been determined to exist.

3. Once ~~individuals~~ members are enrolled in Medicaid, they will receive a letter indicating that they may select one of the contracted MCOs. These letters shall indicate a preassigned MCO, determined as provided in subsection F of this section, in which the ~~individual~~ member will be enrolled if he does not make a selection within a period specified by DMAS of not less than 30 days. Members who are enrolled in one mandatory MCO program who immediately become eligible for another mandatory MCO program are able to maintain consistent enrollment with their currently assigned MCO, if available. These members will receive a notification letter including information regarding their ability to change health plans under the new program.

4. Any newborn whose mother is enrolled with an MCO at the time of birth shall be considered a member of that same MCO for the newborn enrollment period.

a. This requirement does not preclude the member, once he is assigned a Medicaid identification number, from disenrolling from one MCO to enrolling with another in accordance with subdivision H 1 of this section.

b. The newborn's continued enrollment with the MCO is not contingent upon the mother's enrollment. Additionally, if the MCO's contract is terminated in whole or in part, the MCO shall continue newborn coverage if the child is born while the contract is active, until the newborn receives a Medicaid number or for the newborn enrollment period, whichever timeframe is earlier. ~~Children who do not receive a Medicaid identification number prior to the end of the newborn enrollment period will be disenrolled.~~ Newborns who remain eligible for participation in ~~Medallion-H~~ mandatory managed care will be reenrolled in an MCO through the preassignment process upon receiving a Medicaid identification number.

c. Any newborn whose mother is enrolled in an MCO at the time of birth shall receive a Medicaid identification number prior to the end of the newborn enrollment period in order to maintain his enrollment in an MCO.

5. Individuals who lose then regain eligibility for ~~Medallion-H~~ mandatory managed care within 60 days will be reenrolled into their previous MCO without going through preassignment and selection.

G. Individuals who do not select an MCO as described in subdivision F 3 of this section shall be assigned to an MCO as follows:

1. Individuals are assigned through a system algorithm based upon the ~~clients~~ member's history with a contracted MCO.
2. Individuals not assigned pursuant to subdivision 1 of this subsection shall be assigned to the MCO of another family member, if applicable.

3. Individuals who live in rural exception areas as defined in 12VAC30-120-360 ~~must~~ shall enroll with the one available MCO. These ~~persons~~ individuals shall receive a ~~preassignment~~ an assignment notification for enrollment into the MCO. Individuals in rural exception areas who are assigned to the one MCO may request exclusion from MCO participation if their PCP of record, as defined in 12VAC30-120-360, cannot or will not participate with the one MCO in the locality. Individual requests to be excluded from MCO participation in rural exception localities must be made to DMAS for consideration on a case-by-case basis.

4. All other individuals shall be assigned to an MCO on a basis of approximately equal number by MCO in each locality.

5. All eligible members are automatically assigned to a contracted MCO in their localities. Members are allowed 90 days after the effective date of new or initial enrollment to change to another MCO that participates in the geographic area where the member lives. ~~Recipients~~ Individuals residing in localities qualifying for a rural exception shall not be afforded the 90-day window after initial enrollment during which they may make a health plan or program change.

6. DMAS shall have the discretion to utilize an alternate strategy for enrollment or transition of enrollment from the method described in this section for expansions, retractions, or changes to ~~client~~ member populations, geographical areas, procurements, or any or all of these; such alternate strategy shall comply with federal waiver requirements.

H. Following their initial enrollment into an MCO, members shall be restricted to the MCO until the next open enrollment period, unless appropriately disenrolled or excluded by the department (as defined in 12VAC30-120-360).

1. During the first 90 calendar days of enrollment in a new or initial MCO, a member may disenroll from that MCO to enroll into another MCO for any reason. Such disenrollment shall be effective no later than the first day of the second month after the month in which the member requests disenrollment.

2. During the remainder of the enrollment period, the member may only disenroll from one MCO into another MCO upon determination by DMAS that good cause exists as determined under subsection I of this section.

I. The department shall conduct an annual open enrollment for all ~~Medallion-H~~ mandatory managed care members with the exception of those ~~clients~~ members who live in a designated rural exception area. The open enrollment period shall be the 60 calendar days before the end of the enrollment period. Prior to the open enrollment period, DMAS will inform the member of the opportunity to remain with the current MCO or change to another MCO, without cause, for the following year. Enrollment selections will be effective on

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the first day of the next month following the open enrollment period. Members who do not make a choice during the open enrollment period will remain with their current MCO selection.

J. Disenrollment for cause may be requested at any time.

1. After the first 90 days of enrollment in an MCO, members must request disenrollment from DMAS based on cause. The request may be made orally or in writing to DMAS and must cite the reasons why the member wishes to disenroll. Cause for disenrollment shall include the following:

a. A member's desire to seek services from a federally qualified health center that is not under contract with the member's current MCO, and the member requests a change to another MCO that subcontracts with the desired federally qualified health center;

b. Performance or nonperformance of service to the member by an MCO or one or more of its providers that is deemed by the department's external quality review organizations to be below the generally accepted community practice of health care. This may include poor quality care;

c. Lack of access to a PCP or necessary specialty services covered under the State Plan or lack of access to providers experienced in dealing with the member's health care needs;

d. A member has a combination of complex medical factors that, in the sole discretion of DMAS, would be better served under another contracted MCO;

e. The member moves out of the MCO's service area;

f. The MCO does not, because of moral or religious objections, cover the service the member seeks;

g. The member needs related services to be performed at the same time; not all related services are available within the network, and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk; or

h. Other reasons as determined by DMAS through written policy directives.

2. DMAS shall determine whether cause exists for disenrollment. Written responses shall be provided within a timeframe set by department policy; however, the effective date of an approved disenrollment shall be no later than the first day of the second month following the month in which the member files the request, in compliance with 42 CFR 438.56.

3. Cause for disenrollment shall be deemed to exist and the disenrollment shall be granted if DMAS fails to take final action on a valid request prior to the first day of the second month after the request.

4. The DMAS determination concerning cause for disenrollment may be appealed by the member in accordance with the department's client appeals process at 12VAC30-110-10 through ~~12VAC30-110-380~~ 12VAC30-110-370.

5. The current MCO shall provide, within two working days of a request from DMAS, information necessary to determine cause.

6. Members enrolled with a MCO who subsequently meet one or more of the exclusions in subsection B of this section during MCO enrollment shall be excluded as appropriate by DMAS, with the exception of those who subsequently become individuals participating in the IFDDS, ID, EDCD, Day Support, or Alzheimer's federal waiver programs for home-based and community-based Medicaid coverage. These members shall receive acute and primary medical services via the MCO and shall receive waiver services and related transportation to waiver services via the fee-for-service program.

12VAC30-120-380. Medallion-II MCO responsibilities.

A. The MCO shall provide, at a minimum, all medically necessary covered services provided under the State Plan for Medical Assistance and further defined by written DMAS regulations, policies and instructions, except as otherwise modified or excluded in this part.

1. Nonemergency services provided by hospital emergency departments shall be covered by MCOs in accordance with rates negotiated between the MCOs and the hospital emergency departments.

2. Services that shall be provided outside the MCO network shall include, but are not limited to, those services identified and defined by the contract between DMAS and the MCO. Services reimbursed by DMAS include, but shall not be limited to, dental and orthodontic services for children up to age 21; for all others, dental services (as described in 12VAC30-50-190), school health services (as defined in 12VAC30-120-360), community mental health services (rehabilitative, targeted case management and the following substance abuse treatment services: emergency services (crisis); intensive outpatient services; day treatment services; substance abuse case management services; and opioid treatment services), as defined in 12VAC30-50-228 and 12VAC30-50-491, EPSDT Early Intervention services provided pursuant to Part C of the Individuals with Disabilities Education Act (IDEA) of 2004 (as defined in 12VAC30-50-131), and long-term care services provided under the § 1915(c) home-based and community-based waivers including related transportation to such authorized waiver services.

3. The MCOs shall pay for emergency services and family planning services and supplies whether ~~they~~ such services are provided inside or outside the MCO network.

B. EPSDT services shall be covered by the MCO and defined by the contract between DMAS and the MCO. The MCO shall have the authority to determine the provider of service for EPSDT screenings.

C. The MCOs shall report data to DMAS under the contract requirements, which may include data reports, report cards for ~~clients~~ members, and ad hoc quality studies performed by the MCO or third parties.

D. Documentation requirements.

1. The MCO shall maintain records as required by federal and state law and regulation and by DMAS policy. The MCO shall furnish such required information to DMAS, the Attorney General of Virginia or his authorized representatives, or the State Medicaid Fraud Control Unit on request and in the form requested.

2. Each MCO shall have written policies regarding ~~enrollee~~ member rights and shall comply with any applicable federal and state laws that pertain to ~~enrollee~~ member rights and shall ensure that its staff and affiliated providers take those rights into account when furnishing services to ~~enrollees~~ members in accordance with 42 CFR 438.100.

E. The MCO shall ensure that the health care provided to its ~~clients~~ members meets all applicable federal and state mandates, community standards for quality, and standards developed pursuant to the DMAS managed care quality program.

F. The MCOs shall promptly provide or arrange for the provision of all required services as specified in the contract between the ~~state~~ Commonwealth and the ~~contractor~~ MCO. Medical evaluations shall be available within 48 hours for urgent care and within 30 calendar days for routine care. On-call clinicians shall be available 24 hours per day, seven days per week.

G. The MCOs ~~must~~ shall meet standards specified by DMAS for sufficiency of provider networks as specified in the contract between the ~~state~~ Commonwealth and the ~~contractor~~ MCO.

H. Each MCO and its subcontractors shall have in place, and follow, written policies and procedures for processing requests for initial and continuing authorizations of service. Each MCO and its subcontractors shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the ~~enrollee's~~ member's condition or disease. Each MCO and its subcontractors shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions and shall consult with the requesting provider when appropriate.

I. In accordance with 42 CFR 447.50 through 42 CFR 447.60, MCOs shall not impose any cost sharing obligations

on ~~enrollees~~ members except as set forth in 12VAC30-20-150 and 12VAC30-20-160.

J. An MCO may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of ~~an enrollee~~ a member who is his patient in accordance with 42 CFR 438.102.

K. An MCO that would otherwise be required to reimburse for or provide coverage of a counseling or referral service is not required to do so if the MCO objects to the service on moral or religious grounds and furnishes information about the service it does not cover in accordance with 42 CFR 438.102.

12VAC30-120-390. Payment rate for ~~Medallion II~~ MCOs.

The payment rate to MCOs that participate in the mandatory managed care program shall be set by negotiated contracts and in accordance with 42 CFR 438.6 and other pertinent federal regulations.

12VAC30-120-395. Payment rate for preauthorized or emergency care provided by out-of-network providers.

The MCOs shall pay for preauthorized or emergency services when provided outside the MCO network. Preauthorized or emergency services provided to a ~~Medallion II client~~ managed care individual by a provider or facility not participating in the MCO's network will be reimbursed according to the current Medicaid fee schedule. This reimbursement shall be considered payment in full to the provider or facility of emergency services.

12VAC30-120-410. Sanctions.

A. If DMAS determines that an MCO is not in compliance with applicable state or federal laws, regulations (including but not limited to the requirements of or pursuant to 12VAC30-120-380 E, or 42 CFR 438, Subpart I), or ~~their~~ Medallion II the mandatory managed care contract, DMAS may impose sanctions on the MCO. The sanctions may include, but are not limited to:

1. Limiting enrollments in the MCO by freezing voluntary recipient enrollments;
2. Freezing DMAS assignment of recipients to the MCO;
3. Limiting MCO enrollment to specific areas;
4. Denying, withholding, or retracting payments to the MCO;
5. Terminating the MCO's ~~Medallion II~~ contract;
6. Intermediate sanctions including, but not limited to, the maximum civil money penalties specified in 42 CFR Part 438, Subpart I, for the violations set forth therein, or in accordance therewith; and
7. Civil monetary penalties as specified in 42 CFR 438.704.

B. In the case of an MCO that has repeatedly failed to meet the requirements of §§ 1903(m) and 1932 of the Social

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Security Act, DMAS shall, regardless of what other sanctions are imposed, impose the following sanctions:

1. Appoint a temporary manager to:

a. Oversee the operation of the Medicaid managed care organization upon a finding by DMAS that there is continued egregious behavior by the organization or there is a substantial risk to the health of enrollees; or

b. Assure the health of the organization's enrollees if there is a need for temporary management while (i) there is an orderly termination or reorganization of the organization or (ii) improvements are made to remedy the violations found under subsection A of this section. Temporary management under this subdivision may not be terminated until DMAS has determined that the MCO has the capability to ensure that the violations shall not recur.

2. Permit ~~individuals~~ enrollees who are enrolled with the MCO to disenroll without cause. If this sanction is imposed, DMAS shall be responsible for notifying such ~~individuals~~ enrollees of the right to disenroll.

C. Prior to terminating a contract as permitted under subdivision A 5 of this section, DMAS shall provide the MCO with a hearing. DMAS ~~may~~ shall not provide an MCO with a pretermination hearing before the appointment of a temporary manager under subdivision B 1 of this section.

D. Prior to imposing any sanction other than termination of the MCO's contract, DMAS shall provide the MCO with notice, develop procedures with which the MCO must comply to eliminate specific sanctions, and provide such other due process protections as the Commonwealth may provide.

E. In accordance with the terms of the contract, MCOs shall have the right to appeal any adverse action taken by DMAS. For appeal procedures not addressed by the contract, the MCO shall proceed in accordance with the appeals provisions of the Virginia Public Procurement Act (§ 2.2-4300 et seq. of the Code of Virginia). Pursuant to §§ 2.2-4364 and 2.2-4365 of the Code of Virginia, DMAS shall establish an administrative appeals procedure through which the MCO may elect to appeal decisions on disputes arising during the performance of its contract. Pursuant to § 2.2-4365 of the Code of Virginia, such appeal shall be heard by a hearing officer; however, in no event shall the hearing officer be an employee of DMAS. In conducting the administrative appeal, the hearing officer shall follow the hearing procedure used in § 2.2-4020 of the Code of Virginia.

F. When DMAS determines that an MCO committed one of the violations specified in 12VAC30-120-400 A, DMAS shall implement the provisions of 42 CFR 434.67.

1. Any sanction imposed pursuant to this subsection shall be binding upon the MCO.

2. The MCO shall have the appeals rights for any sanction imposed pursuant to this subsection as specified in 42 CFR 434.67.

12VAC30-120-420. ~~Client~~ Member grievances and appeals.

A. The MCOs shall, whenever ~~an enrolled client's~~ a member's request for covered services is reduced, denied or terminated, or payment for services is denied, provide a written notice in accordance with the notice provisions specified in 42 CFR 438.404 and 42 CFR 438.210(c), as defined by the contract between DMAS and the MCO, and any other statutory or regulatory requirements.

B. MCOs shall, at the initiation of either new ~~client member~~ enrollment or new provider/subcontractor contracts, or at the request of the enrollee, provide to every enrollee the information described in 42 CFR 438.10(g) concerning grievance/appeal rights and procedures.

C. Disputes between the MCO and the ~~client member~~ concerning any aspect of service delivery, including medical necessity and specialist referral, shall be resolved through a verbal or written grievance/appeals process operated by the MCO or through the DMAS appeals process. A provider who has the ~~enrollee's~~ member's written consent may act on behalf of ~~an enrollee~~ a member in the MCO grievance/appeals or the DMAS appeals process.

1. The ~~enrollee member~~, provider, or representative acting on behalf of the ~~enrollee member~~ with the ~~enrollee's~~ member's written consent may file an oral or written grievance or appeal with the MCO. The MCO must accept grievances or appeals submitted within 30 days from the date of the notice of adverse action. Oral requests for appeals must be followed up in writing within 10 business days by the ~~enrollee member~~, provider, or the representative acting on behalf of the ~~enrollee member~~ with the ~~enrollee's~~ member's consent, unless the request is for an expedited appeal. The ~~enrollee member~~ may also file a written request for a standard or expedited appeal with the DMAS Appeals Division within 30 days of the ~~client's~~ member's receipt of the notice of adverse action, in accordance with 42 CFR 431, Subpart E; 42 CFR Part 438, Subpart F; and 12VAC30-110.

2. As specified in 12VAC30-110-100, pending the resolution of a grievance or appeal filed by a ~~client member~~ or his representative (including a provider acting on behalf of the ~~client~~ member), coverage shall not be terminated or reduced for the ~~client member~~ for any reason which is the subject of the grievance or appeal.

3. The MCO shall ensure that the ~~individuals~~ employees or agents who make decisions on MCO grievances and appeals were not involved in any previous level of review or decision making, and where the reason for the grievance or appeal involves clinical issues, relates to a denial or a request for an expedited appeal, or where the appeal is based on a lack of medical necessity, shall ensure that the

decision makers are health care professionals with the appropriate clinical expertise in treating the enrollee's condition or disease.

D. The MCO shall develop written materials describing the grievance/appeals system and its procedures and operation.

E. The MCO shall maintain a recordkeeping and tracking system for complaints, grievances, and appeals that includes a copy of the original complaint, grievance, or appeal; the decision; and the nature of the decision. This system shall distinguish Medicaid from commercial enrollees; if the MCO does not have a separate system for Medicaid ~~enrollees~~ members.

F. At the time of enrollment and at the time of any adverse actions, the MCO shall notify the ~~client~~ member, in writing, that:

1. Medical necessity, specialist referral or other service delivery issues may be resolved through a system of grievances and appeals, within the MCO or through the DMAS client appeals process;
2. ~~Clients~~ Members have the right to appeal directly to DMAS; and
3. The MCO shall promptly provide grievance or appeal forms, reasonable assistance and written procedures to ~~clients~~ members who wish to register written grievances or appeals.

G. The MCO shall issue grievance/appeal decisions as defined by the contract between DMAS and the MCO. Oral grievance decisions are not required to be in writing.

H. The MCO shall issue standard appeal decisions within 30 days from the date of initial receipt of the appeal in accordance with 42 CFR 438.408 and as defined by the contract between DMAS and the MCO. The appeal decision shall be in writing and shall include, but shall not be limited to, the following:

1. The decision reached, the results and the date of the decision reached by the MCO;
2. The reasons for the decision;
3. The policies or procedures that provide the basis for the decision;
4. A clear explanation of further appeal rights and a timeframe for filing an appeal; and
5. For appeals that involve the termination, suspension, or reduction of a previously authorized course of treatment, the right to continue to receive benefits in accordance with 42 CFR 438.420 pending a hearing, and how to request continuation of benefits.

I. An expedited appeal decision shall be issued as expeditiously as the ~~enrollee's~~ member's condition requires and within three business days in cases of medical emergencies in which delay could result in death or serious injury to a ~~client~~ member. Extensions to these timeframes shall be allowed in accordance with 42 CFR 438.408 and as

defined by the contract between DMAS and the MCO. Written confirmation of the decision shall promptly follow the verbal notice of the expedited decision.

J. Any appeal decision issued by the MCO may be appealed by the ~~client~~ member to DMAS in accordance with the department's Client Appeals regulations at 12VAC30-110-10 through 12VAC30-110-380. DMAS shall conduct an evidentiary hearing in accordance with the Client Appeals regulations at 12VAC30-110-10 through 12VAC30-110-380 and shall not base any appealed decision on the record established by any appeal decision of the MCO. The MCO shall comply with the DMAS appeal decision. The DMAS decision in these matters shall be final and shall not be subject to appeal by the MCO.

K. The MCO shall provide information necessary for any DMAS appeal within timeframes established by DMAS.

VA.R. Doc. No. R15-4135; Filed December 29, 2014, 1:20 p.m.

Emergency Regulation

Title of Regulation: **12VAC30-141. Family Access to Medical Insurance Security Plan (amending 12VAC30-141-100, 12VAC30-141-120).**

Statutory Authority: §§ 32.1-325 and 32.1-351 of the Code of Virginia; 42 USC § 1396 et seq.

Effective Dates: January 1, 2015, through June 30, 2016.

Agency Contact: Victoria Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-6043, FAX (804) 786-1680, TTY (800) 343-0634, or email victoria.simmons@dmass.virginia.gov.

Preamble:

This action qualifies as an emergency regulation pursuant to § 2.2-4011 A of the Code of Virginia because the Department of Medical Assistance Services (DMAS) has determined that these changes "are necessitated by an emergency situation," consulted with the Attorney General, and received approval from the Governor to promulgate emergency regulations to address the emergency.

Section 32.1-325 of the Code of Virginia grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance and directs that such plan include a provision for the Family Access to Medical Insurance Security (FAMIS) program. Section 32.1-324 of the Code of Virginia authorizes the Director of DMAS to administer and amend the Plan for Medical Assistance when the board is not in session, subject to such rules and regulations as may be prescribed by the board. Section 32.1-351 of the Code of Virginia authorizes the board or the director, as the case may be, to develop and submit to the federal Secretary of Health and Human Services an amended Title XXI plan for the Family Access to Medical Insurance Security Plan and revise such plan and promulgate regulations as may be necessary. Title XXI of the Social Security Act § 2105 (42 USC

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§ 1397ee) provides governing authority for payments for services.

The Patient Protection and Affordable Care Act (PPACA) (2010) permits states to extend eligibility in the Children's Health Insurance Program (CHIP) to children of state employees who are otherwise eligible under the state child health plan, known in Virginia as FAMIS.

State employees have the option of covering their dependent children on their health insurance. However, the employee's contribution to the premium increases approximately \$100 - \$200 per month for adding dependents. For lower income families, this represents a significant reduction in take-home pay. Even with the most comprehensive coverage, employees must also make copayments of up to \$40 for doctor visits when seeking acute care. Thus, lower income state employees may opt for employee-only coverage or may struggle to pay housing costs and other necessities because they are paying for the health insurance dependent coverage.

The FAMIS upper income limit is set at 200% of the Federal Poverty Level (FPL). For a parent with one child, an income of 200% FPL is \$2,622 a month or \$31,460 annually (gross income). The median state salary is \$38,957 a year while the lowest state salary is \$15,371. There are approximately 33,000 state employees with salaries between the lowest and median amounts. The average household size is two. Last year, more than 9,600 full-time state employees qualified for the Earned Income Tax Credit, a federal tax subsidy for lower income working families.

Enrollment in FAMIS has been relatively flat for the past several years, with approximately 500 fewer children covered in July 2014 compared to July 2013. There are more than 100,000 uninsured children across the Commonwealth; the majority of these children are likely to qualify for Medicaid or FAMIS. For those children with a parent employed by the state who do not qualify for Medicaid, the exclusion from enrollment in FAMIS represents a barrier to accessing comprehensive health care benefits.

At this time, a child who is a member of a family that is eligible for subsidized dependent coverage under any Virginia state employee health insurance plan is not eligible for FAMIS. This policy was originally enacted to be compliant with § 2110(b)(2)(B) of the Social Security Act, which categorically excluded dependents of state employees in the definition of a "targeted low-income child."

Virginia's state employee health benefit policies do not allow adding or dropping dependents to coverage outside of the open enrollment period for the new plan year beginning annually on July 1, except in the case of certain qualifying events. Eligibility for Medicaid has been such a qualifying event.

PPACA addresses premium tax credits and cost-sharing through changes to the Internal Revenue Code. The implementation of these rules has drawn wide attention to the issue of "affordable" health insurance. "Some low-to-moderate-income families may be locked out of receiving financial assistance to purchase health coverage through the new health insurance Marketplaces. Eligibility is not solely determined by income. It is also subject to whether a family has access to affordable employer-sponsored insurance. The problem is that the definition of "affordable"--for both an individual employee and a family--is based only on the cost of the employee-only coverage and does not take into consideration the often significantly higher cost of a family plan." ["The Family Glitch", Health Affairs Health Policy Briefs November 10, 2014 http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=129]

The intent of this action is to align Virginia policy with that afforded by changes in federal law, and in doing so expand options for health care coverage to more children in lower income families.

PPACA amended the definition of a targeted low-income child in § 2110(b)(2)(B) of the Social Security Act by permitting states to extend CHIP eligibility to children of state employees who are otherwise eligible under the state child health plan (FAMIS). States now, with an approved CHIP state plan amendment, can enroll such children in these programs. In order to have a state plan amendment approved, the state must meet one of two tests as follows:

- Maintenance of contribution: to meet this test, the amount of annual expenditures made on behalf of each employee enrolled in health coverage paid for by the agency that includes dependent coverage for the most recent state fiscal year is not less than the amount of such expenditures made by the agency for the 1997 state fiscal year, increased by the percentage increase in the medical care expenditure category of the Consumer Price Index for All-Urban Consumers (all items: U.S. City Average) for such preceding fiscal year. This analysis must include data from all agencies with state employees.

- Financial hardship: to meet this test, the state needs to show that the annual aggregate amount of premiums and cost-sharing imposed for coverage of the family of the child would exceed 5.0% of such family's income for the year involved.

An analysis of annual aggregate out-of-pocket expenses for employees of the Commonwealth of Virginia, University of Virginia, and Virginia Commonwealth University Health System Authority demonstrated that Virginia currently meets the financial hardship test. The requisite CHIP state plan amendment has been submitted to the Centers for Medicare & Medicaid Services.

Beginning in January 2015, DMAS and Department of Human Resources Management (DHRM) will allow state employees who do not currently cover their dependent children on their health benefits to enroll their dependent children in FAMIS, if all eligibility standards are met. DMAS is working with DHRM on communication strategies to include: agency website postings of a fact sheet, electronic newsletters to state benefit administrators, inclusion in the annual notice to all state employees about premium assistance, and the state employee open enrollment newsletter for 2015. It is estimated that 5.0% of the eligible state workforce will be impacted by this change, with a resulting 5,000 children enrolled in FAMIS.

Part III

Eligibility Determination and Application Requirements

12VAC30-141-100. Eligibility requirements.

A. This section shall be used to determine eligibility of children for FAMIS.

B. FAMIS shall be in effect statewide.

C. Eligible children must:

1. Be determined ineligible for Medicaid by a local department of social services or be screened by the FAMIS central processing unit and determined not Medicaid likely;
2. Be under 19 years of age;
3. Be residents of the Commonwealth;
4. Be either U.S. citizens, U.S. nationals or qualified noncitizens;
5. Be uninsured, that is, not have comprehensive health insurance coverage; and
- ~~6. Not be a member of a family eligible for subsidized dependent coverage, as defined in 42 CFR 457.310(c)(1)(ii) under any Virginia state employee health insurance plan on the basis of the family member's employment with a state agency; and~~
- ~~7. 6. Not be an inpatient in an institution for mental diseases (IMD), or an inmate in a public institution that is not a medical facility.~~

D. Income.

1. Screening. All child health insurance applications received at the FAMIS central processing unit must be screened to identify applicants who are potentially eligible for Medicaid. Children screened and found potentially eligible for Medicaid cannot be enrolled in FAMIS until there has been a finding of ineligibility for Medicaid. Children who do not appear to be eligible for Medicaid shall have their eligibility for FAMIS determined. Children determined to be eligible for FAMIS will be enrolled in the FAMIS program. Child health insurance applications received at a local department of social services shall have a full Medicaid eligibility determination completed.

Children determined to be ineligible for Medicaid due to excess income will have their eligibility for FAMIS determined. If a child is found to be eligible for FAMIS, the local department of social services will enroll the child in the FAMIS program.

2. Standards. Income standards for FAMIS are based on a comparison of countable income to 200% of the federal poverty level for the family size, as defined in the State Plan for Title XXI as approved by the Centers for Medicare & Medicaid Services. Children who have income at or below 200% of the federal poverty level, but are ineligible for Medicaid due to excess income, will be income eligible to participate in FAMIS.

3. Grandfathered CMSIP children. Children who were enrolled in the Children's Medical Security Insurance Plan at the time of conversion from CMSIP to FAMIS and whose eligibility determination was based on the requirements of CMSIP shall continue to have their income eligibility determined using the CMSIP income methodology. If their income exceeds the FAMIS standard, income eligibility will be based on countable income using the same income methodologies applied under the Virginia State Plan for Medical Assistance for children as set forth in 12VAC30-40-90. Income that would be excluded when determining Medicaid eligibility will be excluded when determining countable income for the former CMSIP children. Use of the Medicaid income methodologies shall only be applied in determining the financial eligibility of former CMSIP children for FAMIS and for only as long as the children meet the income eligibility requirements for CMSIP. When a former CMSIP child is determined to be ineligible for FAMIS, these former CMSIP income methodologies shall no longer apply and income eligibility will be based on the FAMIS income standards.

4. Spenddown. Deduction of incurred medical expenses from countable income (spenddown) shall not apply in FAMIS. If the family income exceeds the income limits described in this section, the individual shall be ineligible for FAMIS regardless of the amount of any incurred medical expenses.

E. Residency. The requirements for residency, as set forth in 42 CFR 435.403, will be used when determining whether a child is a resident of Virginia for purposes of eligibility for FAMIS. A child who is not emancipated and is temporarily living away from home is considered living with his parents, adult relative caretaker, legal guardian, or person having legal custody if the absence is temporary and the child intends to return to the home when the purpose of the absence (such as education, medical care, rehabilitation, vacation, visit) is completed.

F. U.S. citizen or nationality. Upon signing the declaration of citizenship or nationality required by § 1137(d) of the Social Security Act, the applicant or recipient is required under § 2105(c)(9) to furnish satisfactory documentary

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evidence of U.S. citizenship or nationality and documentation of personal identity unless citizenship or nationality has been verified by the Commissioner of Social Security or unless otherwise exempt.

G. Qualified noncitizen. The requirements for qualified aliens set out in Public Law 104-193, as amended, and the requirements for noncitizens set out in subdivisions 3 b, c, and e of 12VAC30-40-10 will be used when determining whether a child is a qualified noncitizen for purposes of FAMIS eligibility.

H. Coverage under other health plans.

1. Any child covered under a group health plan or under health insurance coverage, as defined in § 2791 of the Public Health Services Act (42 USC § 300gg-91(a) and (b)(1)), shall not be eligible for FAMIS.

2. No substitution for private insurance.

a. Only uninsured children shall be eligible for FAMIS. A child is not considered to be insured if the health insurance plan covering the child does not have a network of providers in the area where the child resides. Each application for child health insurance shall include an inquiry about health insurance. Each redetermination of eligibility shall also document inquiry about current health insurance.

b. Health insurance does not include Medicare, Medicaid, FAMIS, or insurance for which DMAS paid premiums under Title XIX through the Health Insurance Premium Payment (HIPP) Program or under Title XXI through the SCHIP premium assistance program.

I. Eligibility of newborns. If a child otherwise eligible for FAMIS is born within the three months prior to the month in which a signed application is received, the eligibility for coverage is effective retroactive to the child's date of birth if the child would have met all eligibility criteria during that time. A child born to a mother who is enrolled in FAMIS, under either the XXI Plan or a related waiver (such as FAMIS MOMS), on the date of the child's birth shall be deemed eligible for FAMIS for one year from birth unless the child is otherwise eligible for Medicaid.

12VAC30-141-120. Children ineligible for FAMIS.

A. If a child is:

1. Eligible for Medicaid, or would be eligible if he applied for Medicaid, he shall be ineligible for coverage under FAMIS. A child found through the screening process to be potentially eligible for Medicaid but who fails to complete the Medicaid application process for any reason, cannot be enrolled in FAMIS;

~~2. A member of a family eligible for coverage under any Virginia state employee health insurance plan, he shall be ineligible for FAMIS;~~

~~3.~~ 2. An inmate of a public institution as defined in 42 CFR 435.1009, he shall be ineligible for FAMIS; or

4. ~~3.~~ An inpatient in an institution for mental disease (IMD) as defined in 42 CFR 435.1010, he shall be ineligible for FAMIS.

B. If a child's parent or other authorized representative does not meet the requirements of assignment of rights to benefits or requirements of cooperation with the agency in identifying and providing information to assist the Commonwealth in pursuing any liable third party, the child shall be ineligible for FAMIS.

C. If a child, if age 18, or if under age 18, a parent, adult relative caretaker, guardian, or legal custodian obtained benefits for a child or children who would otherwise be ineligible by willfully misrepresenting material facts on the application or failing to report changes, the child or children for whom the application is made shall be ineligible for FAMIS. The child, if age 18, or if under age 18, the parent, adult relative caretaker, guardian, or legal custodian who signed the application shall be liable for repayment of the cost of all benefits issued as the result of the misrepresentation.

VA.R. Doc. No. R15-4206; Filed December 29, 2014, 1:17 p.m.



TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARD OF AUDIOLOGY AND SPEECH-LANGUAGE PATHOLOGY

Emergency Regulation

Title of Regulation: 18VAC30-20. Regulations Governing the Practice of Audiology and Speech-Language Pathology (amending 18VAC30-20-10; adding 18VAC30-20-241).

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

Effective Dates: December 29, 2014, through June 28, 2016.

Agency Contact: Leslie L. Knachel, Executive Director, Board of Audiology and Speech-Language Pathology, 9960 Mayland Drive, Suite 300, Richmond, VA 23233-1463, telephone (804) 367-4630, FAX (804) 527-4413, or email leslie.knachel@dhp.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 requires that a regulation be effective in 280 days or less from its enactment. Chapter 327 of the 2014 Acts of the Assembly included such an enactment clause.

The goal of this emergency regulation is to provide a framework for safe practice in an advanced procedure that, before 2014, was not recognized in Virginia as being within the scope of practice of an audiologist. By the change in law and regulation, the practice is expanded to

include limited cerumen management, but the qualifications for such practice and the limitations of practice by an audiologist are essential to protect patients.

Since cerumen management is a more advanced skill in the practice of audiology, requiring additional knowledge and training, the emergency regulations specify the education and specific training necessary to perform it on patients. Additionally, audiologists must know the contraindications for performance by an audiologist and the conditions that require referral to a medical doctor.

Part I
General Provisions

18VAC30-20-10. Definitions.

A. The words and terms "audiologist," "board," "practice of audiology," "practice of speech-language pathology," "speech-language disorders," and "speech-language pathologist" when used in this chapter shall have the meanings ascribed to them in § 54.1-2600 of the Code of Virginia.

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

"Contact hour" means 60 minutes of time spent in continuing learning activities.

"Limited cerumen management" means the identification and removal of cerumen from the cartilaginous outer one-third portion of the external auditory canal in accordance with minimum standards and procedures set forth in this chapter.

"School speech-language pathologist" means a person licensed pursuant to § 54.1-2603 of the Code of Virginia to provide speech-language pathology services solely in public school divisions.

"Supervision" means that the audiologist or speech-language pathologist is responsible for the entire service being rendered or activity being performed, is available for consultation, and is providing regular monitoring and documentation of clinical activities and competencies of the person being supervised.

"Type 1" means continuing learning activities that must be offered by an accredited sponsor or organization as specified in 18VAC30-20-300.

"Type 2" means continuing learning activities that may or may not be approved by an accredited sponsor or organization but shall be activities considered by the learner to be beneficial to practice or to continuing learning. In Type 2 activities, licensees document their own participation on the Continued Competency Activity and Assessment Form and are considered self-learning activities.

18VAC30-20-241. Limited cerumen management.

A. In order for an audiologist to perform limited cerumen management, he shall:

1. Be a graduate of a doctoral program in audiology that is accredited by the Council on Academic Accreditation of the American Speech-Language-Hearing Association and that included didactic education and supervised clinical experience in cerumen management as specified in subsection B of this section; or

2. Complete a course or workshop in cerumen management that provides training as specified in subsection B of this section and that is approved by the American Speech-Language Hearing Association or the American Academy of Audiology.

B. An audiologist shall maintain documentation evidencing satisfactory completion of training in cerumen management to include the following:

1. Recognizing the presence of preexisting contraindications that necessitate referral to a physician;

2. Recognizing patient distress and appropriate action to take if complications are encountered;

3. Use of infection control precautions;

4. Procedures for removal of cerumen, including cerumen loop, gentle water irrigation, suction, and the use of material for softening;

5. Observation of each type of cerumen management procedure performed by a qualified audiologist or physician; and

6. Successful performance, under direct supervision by an audiologist qualified to perform cerumen management or a physician, of each type of cerumen management procedure.

C. An audiologist shall not perform cerumen management on a patient who is younger than 12 years of age or on a patient who has any of the following preexisting contraindications:

1. Hearing in only one ear;

2. A perforated tympanic membrane;

3. Inflammation, tenderness, or open wounds or traces of blood in the external ear canal;

4. Drainage from the external ear canal or middle ear;

5. Current tympanostomy tubes;

6. History of ear surgery, excluding past tympanostomy tubes or simple tympanoplasty;

7. Diabetes mellitus, HIV infection, or bleeding disorders;

8. Actual or suspected foreign body in the ear;

9. Stenosis or bony exostosis of the ear canal;

10. Cerumen impaction that totally occludes the ear canal;
or

11. Inability to see at least 25% of the tympanic membrane.

D. An audiologist performing cerumen management shall:

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1. Obtain informed written consent of the patient or legally responsible adult and maintain documentation of such consent and the procedure performed in the patient record.
2. Refer patients to a physician if they exhibit contraindications or experience any complication, such as dizziness, during the procedure.

VA.R. Doc. No. R15-4115; Filed December 29, 2014, 8:33 a.m.

TITLE 22. SOCIAL SERVICES

DEPARTMENT FOR AGING AND REHABILITATIVE SERVICES

Final Regulation

REGISTRAR'S NOTICE: The State Board of Social Services published proposed amendments to 22VAC40-745, Assessment in Assisted Living Facilities, in 29:7 VA.R. 1334-1343 December 3, 2012, and adopted final amendments on June 20, 2013. The Adult Services, Adult Protective Services, and Auxiliary Grant Programs were transferred from the Department of Social Services to the Department for Aging and Rehabilitative Services (DARS) effective July 1, 2013. As a result, the final amendments published below are incorporated into the DARS regulation numbered 22VAC30-110 as 22VAC40-745 no longer exists.

Title of Regulation: 22VAC30-110. Assessment in Assisted Living Facilities (amending 22VAC30-110-10 through 22VAC30-110-110).

Statutory Authority: § 51.5-131 of the Code of Virginia.

Effective Date: February 25, 2015.

Agency Contact: Paige L. McCleary, MSW, Program Consultant, Adult Protective Services Division, Department for Aging and Rehabilitative Services, 8004 Franklin Farms Drive, Henrico, VA 23229, telephone (804) 662-7605, or email paige.mccleary@dars.virginia.gov.

Summary:

The amendments (i) revise definitions and text to comport with current Department of Social Services licensing regulations; (ii) clarify regulation content related to assessment of individuals applying to or residing in assisted living facilities, determination of services to be provided, and discharge or transition; and (iii) incorporate person-centered language throughout the regulation.

Summary of Public Comments and Agency's Response: No public comments were received by the promulgating agency.

Part I Definitions

22VAC30-110-10. Definitions.

The following words and terms [7] when used in this chapter [7] shall have the following meanings [7] unless the context clearly indicates otherwise:

"Activities of daily living—(ADLs)" or "ADLs" means bathing, dressing, toileting, transferring, bowel control, bladder control, and eating/feeding. ~~A person's~~ An individual's degree of independence in performing these activities is a part of determining appropriate level of care and services.

~~"Applicant" means an adult planning to reside in an assisted living facility.~~

"Administrator" means the licensee or person designated by the licensee who (i) is responsible for the general administration and management of an assisted living facility and who oversees the day-to-day operation of the facility, including compliance with all regulations for assisted living facilities and (ii) meets the requirements of 22VAC40-72.

~~"Assessment" means a standardized approach using common definitions to gather sufficient information about applicants to and residents of assisted living facilities~~ an individual applying to or residing in an assisted living facility to determine the need for appropriate level of care and services.

"Assisted living care" means a level of service provided by an assisted living facility ~~for adults~~ to individuals who may have physical or mental impairments and require at least moderate assistance with the activities of daily living. Moderate assistance means dependency in two or more of the activities of daily living. Included in this level of service are individuals who are dependent in behavior pattern (i.e., abusive, aggressive, disruptive) as documented on the uniform assessment instrument.

~~"Assisted living facility—(ALF)" or "ALF" means any public or private assisted living facility~~ ALF that is required to be licensed as an ~~assisted living facility~~ ALF by the Department of Social Services under Chapter 17 (§ 63.2-1700 et seq.) of Title 63.2 of the Code of Virginia, specifically, any congregate residential setting that provides or coordinates personal and health care services, 24-hour supervision, and assistance (scheduled and unscheduled) for the maintenance or care of four or more adults who are aged, infirm or disabled and who are cared for in a primarily residential setting, except (i) a facility or portion of a facility licensed by the State Board of Health or the Department of Behavioral Health and Developmental Services, but including any portion of such facility not so licensed; (ii) the home or residence of an individual who cares for or maintains only persons related to him by blood or marriage; (iii) a facility or portion of a facility serving infirm or disabled persons between the ages of 18 and 21, or 22 if enrolled in an

educational program for the handicapped pursuant to § 22.1-214 of the Code of Virginia, when such facility is licensed by the Department of Social Services as a children's residential facility under Chapter 17 (§ 63.2-1700 et seq.) of Title 63.2 of the Code of Virginia, but including any portion of the facility not so licensed; and (iv) any housing project for persons 62 years of age or older or the disabled that provides no more than basic coordination of care services and is funded by the U.S. Department of Housing and Urban Development, by the U.S. Department of Agriculture, or by the Virginia Housing Development Authority. Included in this definition are any two or more places, establishments or institutions owned or operated by a single entity and providing maintenance or care to a combined total of four or more aged, infirm or disabled adults. Maintenance or care means the protection, general supervision and oversight of the physical and mental well-being of an aged, infirm or disabled individual. Assuming responsibility for the well-being of individuals, either directly or through contracted agents, is considered general supervision and oversight.

~~"Assisted living facility administrator" means any individual charged with the general administration of an assisted living facility, regardless of whether he has an ownership interest in the facility and meets the requirements of 22VAC40-72.~~

"Auxiliary Grants Program" means a state and locally funded assistance program to supplement the income of a an individual who is receiving Supplemental Security Income (SSI) ~~recipient or adult~~ an individual who would be eligible for SSI except for excess income, and who resides in an assisted living facility ALF with an approved rate.

"Case management" means multiple functions designed to link individuals to appropriate services. Case management may include a variety of common components such as initial screening of need, comprehensive assessment of needs, development and implementation of a plan of care, service monitoring, and follow-up.

"Case management agency" means a public human service agency which employs a case manager or contracts for case management.

"Case manager" means an employee of a public human services agency who is qualified to perform assessments and ~~designated~~ to develop and coordinate plans of care.

~~"Consultation" means the process of seeking and receiving information and guidance from appropriate human services agencies and other professionals when assessment data indicate certain social, physical and mental health conditions.~~

"Department" or "DARS" means the Virginia Department for Aging and Rehabilitative Services.

"Dependent" means, for ~~activities of daily living (ADLs)~~ ADLs and instrumental activities of daily living (IADLs), the individual needs the assistance of another person or needs the assistance of another person and equipment or [a] device to safely complete the activity. For medication administration,

dependent means the individual needs to have medications administered or monitored by another person or professional staff. For behavior pattern, dependent means the ~~person's~~ individual's behavior is aggressive, abusive, or disruptive.

"Discharge" means ~~the movement of a resident out of process that ends an individual's stay in the assisted living facility ALF.~~

"Emergency placement" means the temporary status of an individual in an ~~assisted living facility ALF~~ ALF when the ~~person's~~ individual's health and safety would be jeopardized by not permitting entry into the facility until requirements for admission have been met.

"Facility" means an ~~assisted living facility~~ ALF.

"Independent physician" means a physician who is chosen by ~~the resident of an individual residing in the assisted living facility ALF~~ and who has no financial interest in the ~~assisted living facility ALF~~, directly or indirectly, as an owner, officer, or employee or as an independent contractor with the facility.

"Instrumental activities of daily living (~~IADLs~~)" or "IADLs" means for the purposes of this chapter, meal preparation, housekeeping, laundry, and money management. ~~A person's~~ An individual's degree of independence in performing these activities is a part of determining appropriate level of care and services.

"Maximum physical assistance" means that an individual has a rating of total dependence in four or more of the seven activities of daily living as documented on the uniform assessment instrument.

"Medication administration" means for purposes of this [regulation chapter], assessing the degree of assistance required an individual requires to take medications ~~and is a part of determining the need for in order to determine the individual's appropriate level of care and services.~~

"Private pay" means that ~~a resident of an individual residing in an assisted living facility~~ is not eligible for benefits under the Auxiliary Grants Program.

"Prohibited conditions" means physical or mental health conditions or care needs as described in § 63.2-1805 of the Code of Virginia. An ALF shall not admit or allow the continued residence of an individual with a prohibited condition. Prohibited conditions include, but are not limited to, an individual who requires maximum physical assistance as documented on the uniform assessment instrument and meets nursing facility level of care criteria as defined in the State Plan for Medical Assistance. Unless the individual's independent physician determines otherwise, an individual who requires maximum physical assistance and meets nursing facility level of care criteria as defined on the State Plan for Medical Assistance shall not be admitted to or continue to reside in an ALF.

"Public human services agency" means an agency established or authorized by the General Assembly under

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Chapters 2 and 3 (§§ [~~63.2-203~~ 63.2-200] et seq. and 63.2-300 et seq.) of Title 63.2, Chapter 14 (§ 51.5-116 et seq.) of Title 51.5, Chapters 1 and 5 (§§ 37.2-100 et seq. and 37.2-500 et seq.) of Title 37.2, or Article 5 (§ 32.1-30 et seq.) of Chapter 1 of Title 32.1, or hospitals operated by the state under Chapters 6.1 and 9 (§§ 23-50.4 et seq. and 23-62 et seq.) of Title 23 of the Code of Virginia and supported wholly or principally by public funds, including but not limited to funds provided expressly for the purposes of case management.

"Public pay" means that ~~a resident of an individual residing in an assisted living facility ALF~~ is eligible for benefits under the Auxiliary Grants Program.

"Qualified assessor" means ~~an individual~~ a person who is authorized to perform an assessment, reassessment, or change in level of care for an ~~applicant to or resident of an assisted living facility individual who is seeking admission to an ALF or who resides in an ALF~~. For public pay individuals, a qualified assessor is an employee of a public human services agency who is trained in the completion of the uniform assessment instrument and is authorized to approve placement for an individual who is seeking admission to or residing in an ALF. For private pay individuals, a qualified assessor is staff of the ~~assisted living facility ALF~~ trained in the completion of the uniform assessment instrument or an independent ~~private~~ physician or a qualified assessor for public pay individuals.

"Reassessment" means an update of information on the uniform assessment instrument at any time after the initial assessment. In addition to a ~~periodic~~ annual reassessment, a reassessment ~~should~~ shall be completed whenever there is a significant change in the ~~resident's~~ individual's condition.

~~"Resident" means an individual who resides in an assisted living facility.~~

"Residential living care" means a level of service provided by an ~~assisted living facility ALF~~ for ~~adults~~ individuals who may have physical or mental impairments and require only minimal assistance with the activities of daily living. Minimal assistance means dependency in only one ~~activity of daily living ADL~~ or dependency in one or more of the selected ~~instrumental activities of daily living IADLs as documented on the uniform assessment instrument~~. Included in this level of service are individuals who are dependent in medication administration as documented on the uniform assessment instrument. ~~This~~ The definition of residential living care includes independent living facilities that voluntarily become licensed the services provided by the ALF to individuals who are assessed as capable of maintaining themselves in an independent living status.

"Significant change" means a change in ~~a resident's~~ an individual's condition that is expected to last longer than 30 days. It does not include short-term changes that resolve with or without intervention, a short-term acute illness or episodic event, or a well-established, predictive, cyclic pattern of

clinical signs and symptoms associated with a previously diagnosed condition where an appropriate course of treatment is in progress.

"Targeted case management" means the provision of ongoing case management services by an employee of a public human services agency contracting with the Department of Medical Assistance Services to an ~~auxiliary grant resident of individual who is receiving an auxiliary grant in an assisted living facility ALF~~ who meets the criteria set forth in 12VAC30-50-470.

"Total dependence" means the individual is entirely unable to participate in the performance of an ~~activity of daily living ADL~~.

"Uniform assessment instrument" or "UAI" means the department-designated assessment form. There is an alternate version of the uniform assessment instrument ~~which that~~ may be used for ~~private pay residents; social individuals paying privately. Social~~ and financial information ~~which that~~ is not relevant because of the ~~resident's~~ individual's payment status is not included on ~~this~~ the private pay version.

"User's Manual: Virginia Uniform Assessment Instrument" means the department-designated handbook containing common definitions and procedures for completing the department-designated assessment form.

"Virginia Department of Medical Assistance Services" or "DMAS" means the single state agency designated to administer the Medical Assistance Services Program in Virginia.

Part II Assessment Services

22VAC30-110-20. Persons Individuals to be assessed.

A. All ~~residents of and applicants to assisted living facilities~~ must individuals applying to or residing in an ALF shall be assessed face-to-face using the ~~uniform assessment instrument UAI~~ prior to admission, at least annually, and whenever there is a significant change in the ~~resident's~~ individual's condition.

B. For private pay individuals, qualified staff of the ~~assisted living facility ALF~~ or an independent ~~private~~ physician may complete the ~~uniform assessment instrument UAI~~. Qualified staff ~~of the assisted living facility~~ are ALF employees of the facility who have successfully completed state-approved training on the ~~uniform assessment instrument UAI~~ for either public or private pay assessments. The ~~assisted living facility ALF~~ maintains documentation of the completed training. The administrator or the administrator's designated representative ~~must shall~~ approve and sign the completed ~~uniform assessment instrument UAI~~ for private pay individuals. A private pay individual may request the assessment be completed by a qualified public human services agency assessor. When a public human services agency assessor completes the ~~uniform assessment instrument UAI~~ for a private pay individual, the agency may determine and charge

a fee for private pay applicants and residents; the fee assessments that may not exceed the fee paid by amount DMAS reimburses for public pay applicants and residents assessments.

C. For public pay individuals, a uniform assessment instrument the UAI shall be completed by a case manager or a qualified assessor to determine the need for residential care or assisted living care services. The assessor is qualified to complete the assessment if the assessor has completed a state-approved training course on the state designated uniform assessment instrument UAI. Public human services agency assessors Assessors who prior to January 1, 2004, routinely complete, completed UAIs as part of their job descriptions [;] uniform assessment instruments for applicants to or residents of assisted living facilities prior to January 1, 2004 [;] may be deemed to be qualified assessors without the completion of the training course. Qualified assessors who may initially authorize assisted living facility ALF services for public pay individuals are employees of (i) local departments of social services; (ii) area agencies on aging; (iii) centers for independent living; (iv) community services boards; (v) local departments of health; (vi) state facilities operated by the Department of Behavioral Health and Developmental Services, (vii) acute care hospitals, and (viii) Department of Corrections; and independent physicians. [;]

1. Local departments of social services;
2. Area agencies on aging;
3. Centers for independent living;
4. Community services boards or behavioral health authorities;
5. Local departments of health;
6. State facilities operated by the Department of Behavioral Health and Developmental Services;
7. Acute-care hospitals;
8. Department of Corrections [Community Release Units]; and
9. Independent physicians who have a contract with DMAS to conduct ALF assessments.

D. ~~The assisted living facility must~~ For public pay individuals, the ALF shall coordinate with the assessor to ensure that the uniform assessment instrument UAI is completed as required. If the individual has not been assessed, the local department of social services eligibility worker shall inform the individual or the individual's legal representative of the need to be assessed by a qualified assessor prior to admission. If the individual has not applied for an auxiliary grant, the qualified assessor conducting the assessment shall inform the individual or the individual's legal representative of the need to submit an application for an auxiliary grant.

22VAC30-110-30. Determination of services to be provided.

A. The assessment shall be conducted with the department-designated uniform assessment instrument which using the UAI that sets forth a resident's an individual's care needs. The uniform assessment instrument UAI is designed to be a comprehensive, accurate, standardized, and reproducible assessment of individuals seeking or receiving long-term care services. The uniform assessment instrument UAI is comprised of a short assessment and a full assessment. The short assessment is designed to briefly assess the individual's need for appropriate level of care and services and to determine if a full assessment is needed. The uniform assessment instrument shall contain the following items: Full name of the individual; social security number; current address; date of birth; sex; marital status; racial/ethnic background; education; method for communication of needs; primary caregiver or emergency contact or both; usual living arrangements; problems with physical environmental; use of current formal services; annual income; sources of income; legal representatives; benefits or entitlements received; types of health insurance; performance on functional status which includes ADLs, continence, ambulation and IADLs; physician information; admissions to hospitals, nursing facilities or assisted living facilities for medical or rehabilitation reasons; advance directives; diagnoses and medication profile; sensory functioning; joint motion; presence of fractures/dislocations; missing limbs or paralysis/paresis; nutrition; smoking history; use of rehabilitation therapies; presence of pressure ulcers; need for special medical procedures; need for ongoing medical/nursing needs; orientation; memory and judgment; behavior pattern; life stressors; emotional status; social history which includes activities, religious involvement; contact with family and friends; hospitalization for emotional problems; use of alcohol or drugs; assessment of caregivers; and an assessment summary.

B. Sections The following sections of the uniform assessment instrument which must UAI shall be completed are as follows:

1. The assessment for private pay individuals shall include the following portions of the uniform assessment instrument: name of the individual; social security number; current address; birthdate; sex; marital status; performance on For private pay individuals, the assessment shall include sections related to identification and background, functional status, which includes ADLs, continence, ambulation, IADLs, medication administration, and behavior pattern. In lieu of completing selected parts of the department designated uniform assessment instrument, the alternate uniform assessment instrument developed for private pay applicants and residents The private pay or public pay UAI may be used.

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2. For public pay individuals, the short form of the ~~uniform assessment instrument UAI~~ shall be completed. The short form consists of sections related to identification and background, and functional status (i.e., the first four pages of the UAI), plus sections on medication administration, and behavior pattern. If, upon assessment, it is determined that the individual is dependent in at least two ~~activities of daily living ADLs~~ or is dependent in behavior, then the full assessment ~~must shall~~ be completed.

C. ~~1.~~ The ~~uniform assessment instrument UAI~~ shall be completed within 90 days prior to the date of admission to the ~~assisted living facility ALF~~. If there has been a significant change in the individual's condition since the completion of the ~~uniform assessment instrument which UAI that~~ would affect the admission to an ~~assisted living facility ALF~~, a new ~~uniform assessment instrument UAI~~ shall be completed as specified in 22VAC30-110-20.

~~2.~~ D. When a ~~resident an individual~~ moves to an ~~assisted living facility ALF~~ from another ~~assisted living facility ALF~~, a new ~~uniform assessment instrument UAI~~ is not required except that a new ~~uniform assessment instrument UAI~~ shall be completed whenever there is a significant change in the ~~resident's individual's~~ condition or the assessment was completed more than 12 months ago.

~~3.~~ E. In emergency placements, the ~~uniform assessment instrument must UAI shall~~ be completed within seven working days from the date of placement. An emergency placement shall occur only when the emergency is documented and approved by a Virginia adult protective services worker for public pay individuals or by a Virginia adult protective services worker or independent physician for private pay individuals.

~~D.~~ F. The ~~uniform assessment instrument UAI~~ shall be completed ~~at least~~ annually on all ~~residents of assisted living facilities individuals residing in ALFs~~. ~~Uniform assessment instruments UAIs shall be completed as needed~~ whenever there is a significant change in the ~~resident's individual's~~ condition. All ~~uniform assessment instruments UAIs~~ shall be completed as required by 22VAC30-110-20. The ALF shall provide an area for assessments and reassessment to be conducted that ensures the individual's privacy and protects confidentiality.

~~E.~~ G. At the request of the ~~assisted living facility ALF~~, the ~~resident individual residing in the ALF~~, the ~~resident's individual's legal~~ representative, the ~~resident's individual's~~ physician, the Department of Social Services, or the local department of social services, an independent assessment using the ~~uniform assessment instrument UAI~~ shall be completed to determine whether the ~~resident's individual's~~ care needs are being met in the current ~~placement ALF~~. An independent assessment is an assessment that is completed by an entity other than the original assessor. The ~~assisted living facility ALF~~ shall assist the ~~resident individual~~ in obtaining the independent assessment as requested. If the request is for

a private pay ~~resident individual, and the independent assessment confirms that the resident's placement is appropriate, then~~ the entity requesting the independent assessment shall be responsible for ~~payment of~~ paying for the assessment, ~~if applicable.~~

~~F.~~ H. The assessor shall consult with other appropriate human service professionals as needed to complete the assessment.

~~G.~~ I. DMAS shall reimburse for completion of assessments and authorization of ~~assisted living facility ALF~~ placement for public pay ~~applicants and residents individuals~~ pursuant to this section.

22VAC30-110-40. Discharge.

A. Discharge is the process that ends the stay in an assisted living facility. Staff of the assisted living facility ~~must plan for post discharge services when the public pay resident is returned to a home based placement, a nursing facility, or other placement ALF~~ staff shall assist the individual and legal representative in the discharge or transfer process. Assisted living facility ~~For public pay individuals, ALF~~ staff shall ~~notify in writing~~ provide written notification of the individual's date and place of discharge or of the individual's death to the local department of social services ~~financial~~ eligible worker in the jurisdiction responsible for authorizing the auxiliary grant and the ~~public human services agency qualified~~ assessor of the date and place of discharge as well as when a resident dies ~~who conducted the most recent assessment~~. The ~~assisted living facility must ALF~~ shall make these notifications at least 14 calendar days prior to the ~~resident's individual's~~ planned discharge or within five calendar days after the ~~individual's death of the resident~~. In the event of an emergency discharge as ~~defined by~~ specified in 22VAC40-72-420, the notification shall be made as rapidly as possible, but must be made by close of business on the day following the emergency discharge.

B. Upon issuing a notice of summary order of suspension to an ~~assisted living facility ALF~~, the Commissioner of the Virginia Department of Social Services or his designee shall contact the appropriate local department of social services to develop a relocation plan. ~~The residents of an assisted living facility Individuals residing in an ALF~~ whose license has been summarily suspended pursuant to § 63.2-1709 of the Code of Virginia shall be relocated as soon as possible to reduce the risk of ~~jeopardizing the to their~~ health, safety, and welfare of residents. ~~An assessment of the relocated resident is~~ New assessments of the individuals who are relocating are not required, pursuant to 22VAC30-110-30 ~~C-2 D.~~

22VAC30-110-50. Authorization of services to be provided.

A. The assessor is responsible for authorizing public payment to the individual for the appropriate level of care ~~for~~ upon admission [to] and for continued stay in an ~~assisted living facility ALF~~.

B. The ~~assisted living facility must~~ ALF staff shall be knowledgeable of the criteria for level of care in an ~~assisted living facility ALF~~ and ~~is are~~ responsible for ~~discharge of the resident whenever a resident~~ discharging the individual when the individual does not meet the criteria for level of care in an ~~assisted living facility ALF~~ upon admission or at any later time.

C. The appropriate level of care ~~must shall~~ be documented on the ~~uniform assessment instrument UAI, and~~ completed in a manner consistent with the definitions of ~~activities of daily living ADLs~~ and directions provided in the User's Manual: Virginia Uniform Assessment Instrument as well as the requirements set forth in this chapter.

D. During an inspection or review, staff from ~~either~~ [the Department of Social Services], ~~DMAS, [DSS]~~ or the local department of social services may initiate a change in level of care for any ~~assisted living facility resident individual~~ residing in the ALF for whom it is determined that the ~~resident's uniform assessment instrument is not reflective of UAI does not reflect the resident's individual's~~ current status.

22VAC30-110-60. Criteria for residential living care.

Individuals shall meet the criteria for residential living as documented on the ~~uniform assessment instrument UAI~~ when at least one of the following describes their functional capacity:

1. Rated dependent in only one of seven ADLs (i.e., bathing, dressing, toileting, transferring, bowel function, bladder function, and eating/feeding).
2. Rated dependent in one or more of four selected IADLs (i.e., meal preparation, housekeeping, laundry, and money management).
3. Rated dependent in medication administration.

22VAC30-110-70. Criteria for assisted living care.

Individuals shall meet the criteria for assisted living as documented on the ~~uniform assessment instrument UAI~~ when at least one of the following describes their capacity:

1. Rated dependent in two or more of seven ADLs.
2. Rated dependent in behavior pattern (i.e., abusive, aggressive, and disruptive).

22VAC30-110-80. Rating of levels of care on the uniform assessment instrument.

A. The rating of functional dependencies on the ~~uniform assessment instrument must~~ UAI shall be based on the individual's ability to function in a community environment.

B. ~~The~~ For purposes of this chapter, the following abbreviations shall mean: D = dependent; and TD = totally dependent. Mechanical help means equipment or a device or both are used; human help includes supervision and physical assistance. Asterisks (*) denote dependence in a particular function.

1. Activities of daily living.

- a. Bathing.
 - (1) Without help
 - (2) Mechanical help only
 - (3) Human help only* (D)
 - (4) Mechanical help and human help* (D)
 - (5) Is performed by others* (TD)

- b. Dressing.
 - (1) Without help
 - (2) Mechanical help only
 - (3) Human help only* (D)
 - (4) Mechanical help and human help* (D)
 - (5) Is performed by others* (TD)
 - (6) Is not performed* (TD)

- c. Toileting.
 - (1) Without help
 - (2) Mechanical help only
 - (3) Human help only* (D)
 - (4) Mechanical help and human help* (D)
 - (5) Performed by others* (TD)
 - (6) Is not performed* (TD)

- d. Transferring.
 - (1) Without help
 - (2) Mechanical help only
 - (3) Human help only* (D)
 - (4) Mechanical help and human help* (D)
 - (5) Is performed by others* (TD)
 - (6) Is not performed* (TD)

- e. Bowel function.
 - (1) Continent
 - (2) Incontinent less than weekly
 - (3) Ostomy self-care
 - (4) Incontinent weekly or more* (D)
 - (5) Ostomy not self-care* (TD)

- f. Bladder function.
 - (1) Continent
 - (2) Incontinent less than weekly
 - (3) External device, indwelling catheter, ostomy, self-care
 - (4) Incontinent weekly or more* (D)
 - (5) External device, not self-care* (TD)
 - (6) Indwelling catheter, not self-care* (TD)
 - (7) Ostomy, not self-care* (TD)

- g. Eating/feeding.
 - (1) Without help

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- (2) Mechanical help only
- (3) Human help only* (D)
- (4) Mechanical help and human help* (D)
- (5) Performed by others (includes spoon fed, syringe/tube fed, fed by IV)* (TD)

2. Behavior pattern.

- a. Appropriate
- b. Wandering/passive less than weekly
- c. Wandering/passive weekly or more
- d. Abusive/aggressive/disruptive less than weekly* (D)
- e. Abusive/aggressive/disruptive weekly or more* (D)

3. Instrumental activities of daily living.

- a. Meal preparation.
 - (1) No help needed
 - (2) Needs help* (D)
- b. Housekeeping.
 - (1) No help needed
 - (2) Needs help* (D)
- c. Laundry.
 - (1) No help needed
 - (2) Needs help* (D)
- d. Money management.
 - (1) No help needed
 - (2) Needs help* (D)

4. Medication administration.

- a. Without assistance
- b. Administered/monitored by lay person* (D)
- c. Administered/monitored by professional staff* (D)

22VAC30-110-90. Actions to be taken upon completion of the uniform assessment instrument.

A. Public pay individuals.

1. Upon completion of the ~~uniform assessment instrument~~ UAI for admission, a significant change in the ~~resident's~~ individual's condition, or the annual reassessment, the case manager or a qualified assessor shall forward to the local department of social services ~~financial~~ eligibility worker in the appropriate agency of jurisdiction, in the format specified by the department, the effective date of admission or change in level of care. Qualified assessors who ~~may~~ are authorized to perform the annual reassessment or a change in level of care for public pay individuals are employees of (i) local departments of social services; (ii) area agencies on aging; (iii) centers for independent living; (iv) community services boards or behavioral health authority; and (v) local departments of health, or an independent physician ~~to complete the uniform assessment instrument~~ who has a contract with DMAS to conduct assessments.

2. The completed ~~uniform assessment instrument~~ UAI, the referral to the ~~financial~~ eligibility worker, and other relevant data shall be maintained in the individual's record at the assisted living facility resident's record ALF.

3. The annual reassessment shall be completed by the qualified assessor conducting the initial assessment. If the original assessor is neither willing nor able to complete the assessment and another assessor is not available, the local department of social services where the ~~resident~~ individual resides ~~following placement in an assisted living facility in the ALF~~ shall be the assessor, except that individuals who receive services from a community service board or behavioral health authority shall be assessed and reassessed by qualified assessors employed by the community services board or behavioral health authority.

~~4. Clients of a community services board shall be assessed and reassessed by qualified assessors employed by the community services board.~~

~~5.~~ 4. The facility ALF shall ~~provide to~~ notify the community services board or behavioral health authority ~~notification of uniform assessment instruments that when UAIs~~ indicate observed behaviors or patterns of behavior indicative of mental illness, intellectual disability, substance abuse, or behavioral disorders, pursuant to § 63.2-1805 B of the Code of Virginia.

B. For private pay ~~residents~~ individuals, the ~~assisted living facility~~ ALF shall ensure that assessments for all ~~residents~~ individuals at admission and at subsequent intervals are completed as required in this chapter. The ~~assisted living facility~~ ALF shall maintain ~~in the resident's record the resident's uniform assessment instrument~~ the individual's UAI and other relevant data in the individual's ALF record.

22VAC30-110-100. Targeted case management for ~~auxiliary grant recipients~~ individuals receiving an auxiliary grant.

A. Targeted case management shall be limited to those ~~residents~~ individuals who have multiple needs across multiple providers and this coordination is beyond the scope of the ~~assisted living facility~~ ALF. It shall be the responsibility of the assessor who identifies the individual's need for residential care or assisted living care in an ~~assisted living facility~~ ALF to assess the need for targeted case management ~~services~~ as defined in 12VAC30-50-470.

B. A case management agency ~~must~~ shall have signed an agreement with DMAS to be reimbursed for the provision of targeted case management ~~services to auxiliary grant recipients~~ for individuals receiving an auxiliary grant.

C. The local department of social services where the ~~adult~~ individual resides, following ~~placement in an assisted living facility~~ admission to an ALF, shall be the case management agency when there is no other qualified case management provider willing or able to provide case management ~~services.~~

D. A qualified case manager ~~must~~ shall possess a combination of relevant work experience in human services or health care and relevant education which indicates that the individual possesses the knowledge, skills, and abilities at entry level as defined in 12VAC30-50-470. This must be documented on the case manager's job application form or supporting documentation [~~or observable in the job or promotion interview~~]. When the provider agency is a local department of social services, case managers shall meet the qualifications for [~~social work/social work supervisor classification~~ family services occupational group] as specified in ~~22VAC40-670~~ 22VAC40-670-20.

Part III
Resident Appeals

22VAC30-110-110. Resident ~~appeals~~ [Appeals Notifications].

Assessors shall advise orally and in writing all ~~applicants to and residents of assisted living facilities public pay individuals~~ [for] which [~~whom~~ assessment or targeted case management services or both are provided of the right to appeal of] the outcome of the assessment [; or] the annual reassessment, [~~or determination of level of care including a statement indicating that the local department of social services will notify the individual whether he is eligible to receive the auxiliary grant~~]. Applicants for auxiliary grants An individual who ~~are~~ is denied an auxiliary grant because the assessor determines that ~~they do~~ the individual does not [~~require the minimum level of services offered in the meet the care needs for~~] residential ~~care level~~ have of care has the right to file an appeal with the Department of Social Services under § 63.2-517 of the Code of Virginia. [Notification of the right to appeal will be included in the notice of action provided by the local department of social services.] A determination that the individual does not meet the criteria to receive [~~assisted living level of care targeted case management~~] is an action [~~which that~~] is appealable to DMAS [in accordance with the provisions of 12VAC30-110].

NOTICE: The following forms used in administering the regulation were filed by the agency. The forms are not being published; however, online users of this issue of the Virginia Register of Regulations may click on the name to access a form. The forms are also available from the agency contact or may be viewed at the Office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Richmond, Virginia 23219.

FORMS (22VAC30-110)

[Virginia Uniform Assessment Instrument for Private Pay Residents of Assisted Living Facilities \(rev. 1/10\)](#)

[Virginia Uniform Assessment Instrument, \[~~UAI \(1994\)~~ Virginia Long-Term Care Council \(1994; reformatted May 2000, Virginia Department of Social Services\) \]](#)

DOCUMENTS INCORPORATED BY REFERENCE (22VAC30-110)

~~User's Manual: Virginia Uniform Assessment Instrument (UAI), Commonwealth of Virginia, Revised April 1998.~~

[User's Manual: Virginia Uniform Assessment Instrument \(UAI\), Commonwealth of Virginia \(rev. 7/05\)](#)

VA.R. Doc. No. R11-2585; Filed December 11, 2014, 10:48 a.m.

GENERAL NOTICES/ERRATA

DEPARTMENT OF HEALTH

Drinking Water State Revolving Fund Program - Intended Use Plan for Fiscal Year 2015

Under the Safe Drinking Water Act, Congress authorizes capitalization grants to the states through the Drinking Water State Revolving Loan Fund Program (DWSRF). As part of the annual DWSRF grant application process, Virginia seeks meaningful public involvement through input, review, and comments. The Virginia Department of Health (VDH), Office of Drinking Water (ODW) has prepared a draft intended use plan (IUP) that explains the goals of the program, funding priorities, how VDH intends to use the grant funds, and other important information submitted from the funding requests and set-aside suggestions.

VDH received numerous funding requests and set-aside suggestions following the January 2015 DWSRF funding solicitation announcement. The draft 2015 IUP and draft project lists are open for review and comment by the public for a period of 60 days. The document entitled "Virginia Drinking Water State Revolving Fund Program Design Manual" (dated January 2014) is a part of the intended use plan and was mailed to eligible waterworks in January 2014, announced in the Virginia Register, and placed on our website (<http://www.vdh.virginia.gov/odw>). The Program Design Manual provides information on VDH's project prioritization criteria and methodologies.

VDH will hold a public meeting to solicit comments and recommendations regarding the 2015 IUP on Thursday, February 19, 2015, from 9 a.m. to 11 a.m. at the ODW's East Central Field Office, 300 Turner Road, Richmond, VA 23225. Those individuals planning to attend the public meeting should contact Theresa Hewlett at (804) 864-7501 by the close of business on February 12, 2015.

Any written comments from the public are to be submitted by March 29, 2015, the close of the public comment period. VDH will consider all meaningful public input and comments and make revisions to the IUP and project priority lists if necessary. Please direct requests for information and forward written comments to Steven Pellei, PE, Virginia Department of Health, Office of Drinking Water, James Madison Building, 109 Governor Street, Richmond, VA 23219, telephone (804) 864-7500, FAX (804) 864-7521. The following information should be provided on VDH's website by February 1, 2015, at <http://www.vdh.virginia.gov/ODW/FinancialandConstruction.htm>:

VDH's 2015 Preliminary Project Priority List/2015 Comprehensive Project List

VDH's 2015 Draft Intended Use Plan (IUP) - The IUP is subject to change depending on EPA's 2015 award allocations.

VDH's 2015 Planning Grant Award List - The projects listed will be awarded grants in the amounts indicated on the table.

VIRGINIA LOTTERY

Director's Orders

The following Director's Orders of the Virginia Lottery were filed with the Virginia Registrar of Regulations on December 30, 2014. The orders may be viewed at the Virginia Lottery, 900 East Main Street, Richmond, Virginia, or at the office of the Registrar of Regulations, 201 North 9th Street, 2nd Floor, Richmond, Virginia.

Director's Order Number One Hundred Sixty-Four (14)

Virginia's Instant Game Lottery 1527 "Throw Back To The 70s" Final Rules for Game Operation (effective December 24, 2014)

Director's Order Number One Hundred Sixty-Five (14)

Virginia's Instant Game Lottery 1528 "Throw Back To The 80s" Final Rules for Game Operation (effective December 24, 2014)

Director's Order Number One Hundred Sixty-Six (14)

Virginia's Instant Game Lottery 1529 "Throw Back To The 90s" Final Rules for Game Operation (effective December 24, 2014)

Director's Order Number One Hundred Sixty-Seven (14)

Virginia's Instant Game Lottery 1530 "Double Match" Final Rules for Game Operation (effective December 24, 2014)

Director's Order Number One Hundred Sixty-Eight (14)

Virginia Lottery's "2015 Super Teacher Awards Contest" Final Rules for Operation (This Director's Order becomes effective on January 5, 2015, and shall remain in full force and effect unless amended or rescinded by further Director's Order)

Director's Order Number One Hundred Seventy-Two (14)

Virginia Lottery's "Premium Membership Coupon Promotion" Final Rules For Operation (This Director's Order is effective nunc pro tunc to Thursday, July 3, 2014, fully replaces any and all prior Virginia Lottery premium membership upgrade coupon promotion rules, and shall remain in full force and effect unless amended or rescinded by further Director's Order)

Director's Order Number One Hundred Seventy-Five (14)

Virginia's Instant Game Lottery 1532 "\$40,000 Jackpot" Final Rules for Game Operation (effective December 24, 2014)

Director's Order Number One Hundred Seventy-Six (14)

Virginia's Instant Game Lottery 1540 "Money Maker" Final Rules for Game Operation (effective December 24, 2014)

Director's Order Number One Hundred Seventy-Seven (14)

Virginia's Instant Game Lottery 1541 "The Color Of Money" Final Rules for Game Operation (effective December 24, 2014)

Director's Order Number One Hundred Seventy-Eight (14)

Virginia's Instant Game Lottery 1539 "Spicy Hot Cash" Final Rules for Game Operation (effective December 24, 2014)

Director's Order Number One Hundred Seventy-Nine (14)

Virginia's Instant Game Lottery 1542 "\$3,000,000 Silver Spectacular" Final Rules for Game Operation (effective December 24, 2014)

STATE WATER CONTROL BOARD

Proposed Consent Special Order for New Kent County Board of Supervisors

An enforcement action has been proposed for the New Kent County Board of Supervisors, for alleged violations that occurred at the New Kent County Airport, Quinton, Virginia. The State Water Control Board proposes to issue a consent special order to the New Kent County Board of Supervisors to address noncompliance with State Water Control Law. 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>. Cynthia Akers will accept comments by email at cynthia.akers@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 January 26, 2015, through February 25, 2015.

Proposed Enforcement Action for Universal Air and Vacuum Services, LLC

An enforcement action has been proposed for Universal Air and Vacuum Services, LLC. The consent order describes a settlement to resolve violations of State Water Control Law and the applicable regulations associated with the vehicle wash facility at the Arna Valley Exxon Station located in Arlington, 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>. 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 January 27, 2015, through February 26, 2015.

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 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.

ERRATA

STATE BOARD OF SOCIAL SERVICES

Title of Regulation: 22VAC40-880. **Child Support Enforcement Program.**

Publication: 31:10 VA.R. 910-925 January 12, 2015.

Correction to Final Regulation:

Page 910, Effective Date, change "2014" to "2015"

VA.R. Doc. No. R11-2892; Filed January 6, 2015, 10:30 a.m.

