VIRGINIA REGISTER OF REGULATIONS

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TABLE OF CONTENTS

Register Information Page 1223

Publication Schedule and Deadlines 1224

Petitions for Rulemaking 1225

Notices of Intended Regulatory Action 1226

Regulations 1227

1VAC30-150. Regulations for Public Use of Robert E. Lee Monument, Richmond, VA (Proposed) 1227
8VAC115-30. Richard Bland College Weapons on Campus Regulation (Final) 1232
8VAC115-50. Richard Bland College Open Flames on Campus (Final) 1233
11VAC10-60. Participants (Final) 1234
12VAC5-490. Virginia Radiation Protection Regulations: Fee Schedule (Final) 1235
12VAC30-50. Amount, Duration, and Scope of Medical and Remedial Care Services (Fast-Track) 1238
12VAC30-130. Amount, Duration, and Scope of Selected Services (Fast-Track) 1238
12VAC30-130. Amount, Duration, and Scope of Selected Services (Fast-Track) 1260
12VAC35-105. Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services (Fast-Track) 1264
12VAC35-210. Regulations to Govern Temporary Leave from State Mental Health and State Mental Retardation Facilities (Fast-Track) 1273
13VAC10-180. Rules and Regulations for Allocation of Low-Income Housing Tax Credits (Final) 1278
16VAC30-16. Electronic Medical Billing (Final) 1303
18VAC65-20. Regulations of the Board of Funeral Directors and Embalmers (Fast-Track) 1310
18VAC90-19. Regulations Governing the Practice of Nursing (Fast-Track) 1312
18VAC90-21. Medication Administration Training and Immunization Protocol (Fast-Track) 1314
18VAC90-30. Regulations Governing the Licensure of Nurse Practitioners (Emergency) 1315
18VAC90-40. Regulations for Prescriptive Authority for Nurse Practitioners (Emergency) 1315
18VAC110-20. Regulations Governing the Practice of Pharmacy (Final) 1319
18VAC140-20. Regulations Governing the Practice of Social Work (Proposed) 1320
22VAC30-20. Provision of Vocational Rehabilitation Services (Final) 1322
22VAC30-80. Auxiliary Grants Program (Final) 1323
22VAC40-677. State Oversight of a Local Social Services Department that Fails to Provide Services (Emergency) 1328

Governor 1330

General Notices/Errata 1333

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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. **34:8 VA.R. 763-832 December 11, 2017,** refers to Volume 34, Issue 8, pages 763 through 832 of the *Virginia Register* issued on December 11, 2017.

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

PUBLICATION SCHEDULE AND DEADLINES

This schedule is available on the Virginia Register of Regulations website (http://register.dls.virginia.gov).

February 2019 through December 2019

Volume: Issue	Material Submitted By Noon*	Will Be Published On
35:12	January 16, 2019	February 4, 2019
35:13	January 30, 2019	February18, 2019
35:14	February 13, 2019	March 4, 2019
35:15	February 27, 2019	March 18, 2019
35:16	March 13, 2019	April 1, 2019
35:17	March 27, 2019	April 15, 2019
35:18	April 10, 2019	April 29, 2019
35:19	April 24, 2019	May 13, 2019
35:20	May 8, 2019	May 27, 2019
35:21	May 22, 2019	June 10, 2019
35:22	June 5, 2019	June 24, 2019
35:23	June 19, 2019	July 8, 2019
35:24	July 3, 2019	July 22, 2019
35:25	July 17, 2019	August 5, 2019
35:26	July 31, 2019	August 19, 2019
36:1	August 14, 2019	September 2, 2019
36:2	August 28, 2019	September 16, 2019
36:3	September 11, 2019	September 30, 2019
36:4	September 25, 2019	October 14, 2019
36:5	October 9, 2019	October 28, 2019
36:6	October 23, 2019	November 11, 2019
36:7	November 6, 2019	November 25, 2019
36:8	November 18, 2019 **(Monday)**	December 9, 2019
36:9	December 4, 2019	December 23, 2019

*Filing deadlines are Wednesdays unless otherwise specified.

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARD OF DENTISTRY

Agency Decision

Title of Regulation: **18VAC60-21. Regulations Governing the Practice of Dentistry.**

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

Name of Petitioner: Nicholas Ilchyshyn, DDS.

Nature of Petitioner's Request: To allow dentists who serve as preceptors for dental students to receive continuing education credit for such work.

Agency Decision: Request denied.

Statement of Reason for Decision: The petition was considered by the board at its meeting on December 14, 2018. While the board is fully supportive of mentoring and appreciative of licensees who perform those duties, it has declined to amend the regulations to use those hours for continuing education. The hours recognized by the Board of Medicine may be used to satisfy Type 2 hours, but not Type 1 hours. The Board of Medicine requires 60 hours per biennium, at least half of which must be Type 1 hours. The Board of Dentistry requires 15 hours for annual renewal and does not recognize hours that are not approved by an accredited sponsor or organization.

Agency Contact: Sandra Reen, Executive Director, Board of Dentistry, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4437, or email sandra.reen@dhp.virginia.gov.

VA.R. Doc. No. R18-38; Filed December 14, 2018, 2:24 p.m.

BOARD OF LONG-TERM CARE ADMINISTRATORS

Agency Decision

Title of Regulation: **18VAC95-30. Regulations Governing the Practice of Assisted Living Facility Administrators.**

Statutory Authority: §§ 54.1-2400 and 54.1-3102 of the Code of Virginia.

Name of Petitioner: Daniel Cassiere.

Nature of Petitioner's Request: The petitioner requests amendments to (i) allow an administrator with one year of total experience to be a preceptor, (ii) make it mandatory for an employer to inform the board about employee work dates, and (iii) add other types of documents to prove work history.

Agency Decision: Request denied.

Statement of Reason for Decision: At its meeting on December 13, 2018, the board considered the petition and comments received and decided to retain the current requirements. While members appreciated the petitioner's point of view, it was their conclusion that the requirement of one-year of full-time employment as an administrator is the minimal amount of experience necessary to adequately serve as a preceptor for an administrator-in-training. Additionally, the board did not accept the request to require facilities to verify employment or to accept other means of verification. The board does not license or regulate the facilities, only the administrators of those facilities, and acceptance of pay stubs may not adequately provide evidence of full-time employment.

Agency Contact: Corie Tillman Wolf, Executive Director, Board of Long-Term Care Administrators, 9960 Mayland Drive, Suite 300, Richmond, VA 23233-1463, telephone (804) 367-4595, or email corie.wolf@dhp.virginia.gov.

VA.R. Doc. No. R19-10; Filed December 14, 2018, 8:53 a.m.

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARD OF NURSING

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 intends to consider amending **18VAC90-30, Regulations Governing the Licensure of Nurse Practitioners**, and **18VAC90-40, Regulations for Prescriptive Authority for Nurse Practitioners**. The purpose of the proposed action is to set the qualifications for authorization for a nurse practitioner to practice without a practice agreement with a patient care team physician, including the hours required to be the equivalent of five years of full-time clinical experience, the content of the attestation from the physician and nurse practitioner, the submission of an attestation when the nurse practitioner is unable to obtain a physician attestation, the requirements for autonomous practice, and the fee for authorization for autonomous practice.

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

Statutory Authority: §§ 54.1-2400 and 54.1-2957 of the Code of Virginia.

Public Comment Deadline: February 6, 2019.

Agency Contact: Jay P. Douglas, R.N., Executive Director, Board of Nursing, 9960 Mayland Drive, Suite 300, Richmond, VA 23233-1463, telephone (804) 367-4520, FAX (804) 527-4455, or email jay.douglas@dhp.virginia.gov.

VA.R. Doc. No. R19-5512; Filed December 19, 2018, 9:45 a.m.

TITLE 22. SOCIAL SERVICES

STATE BOARD OF SOCIAL SERVICES

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the State Board of Social Services intends to consider promulgating **22VAC40-677, State Response When a Local Department of Social Services Fails to Provide Services**. The purpose of the proposed action is to provide the Commissioner of the Department of Social Services with regulatory authority to direct and oversee the provision of public assistance and social services in a local department of social services in the event the local department fails, refuses, or is unable to provide such services as prescribed in Subtitles II (§ 63.2-500 et seq.) and III (§ 63.2-900 et seq.) of Title 63.2 of the Code of Virginia.

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

Statutory Authority: §§ 63.2-217 and 63.2-408 of the Code of Virginia.

Public Comment Deadline: February 6, 2019.

Agency Contact: Karin Clark, Regulatory Coordinator, Department of Social Services, 801 East Main Street, Richmond, VA 23219, telephone (804) 726-7017, FAX (804) 726-7015, or email karin.clark@dss.virginia.gov.

VA.R. Doc. No. R19-5464; Filed December 17, 2018, 1:00 p.m.

TITLE 1. ADMINISTRATION

DEPARTMENT OF GENERAL SERVICES

Proposed Regulation

Title of Regulation: **1VAC30-150. Regulations for Public Use of Robert E. Lee Monument, Richmond, VA (adding 1VAC30-150-10 through 1VAC30-150-50).**

Statutory Authority: § 2.2-1100 of the Code of Virginia.

Public Hearing Information:

March 6, 2019 - 10 a.m. - Department of General Services, 1100 Bank Street, Richmond, VA 23219

Public Comment Deadline: March 8, 2019.

Agency Contact: Rhonda Bishton, Director's Executive Administrative Assistant, Department of General Services, 1100 Bank Street, Suite 420, Richmond, VA 23219, telephone (804) 786-3311, FAX (804) 371-8305, or email rhonda.bishton@dgs.virginia.gov.

Basis: Section 2.2-1102 A 1 of the Code of Virginia authorizes the Department of General Services to prescribe regulations necessary or incidental to the performance of the department's duties or execution of powers conferred by the Code of Virginia. Executive Order 67 (2017) directed the department to promulgate this regulation.

Purpose: This regulation is promulgated to replace emergency regulations issued in response to the events of August 2017, when a "Unite the Right" rally evolved into a violent incident of civil unrest in Charlottesville, Virginia and necessitated a State of Emergency declaration by then Governor, Terence R. McAuliffe, to address the violence. Executive Order 67 details the rationale for requiring a review of the regulations at the Lee Monument, and that rationale is incorporated by reference here. Executive Order 67 was published in 34:2 VA.R. 393 September 18, 2017. This stage begins the regulatory process to make the proposed regulations permanent.

Substance: No substantive changes from the emergency regulations, which were published in 34:8 VA.R. 767-769 December 11, 2017.

Issues: The primary advantage of this regulation is that it offers guidelines for public assembly at the Robert E. Lee Monument, which seek to protect public safety, Commonwealth-owned property, and the residents and property around the monument, while providing a space for members of the public to exercise their First Amendment rights. The disadvantage of the regulation is that it limits the times for public assembly, the items allowed during a permitted event, and the number of attendees in an effort to maximize safety in this unique space situated in a residential area in the middle of a heavily traveled intersection.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The Department of General Services (DGS) proposes to promulgate a permanent regulation for public use of the Robert E. Lee Monument.

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

Estimated Economic Impact. The statute of Robert E. Lee located at 1700 Monument Avenue in Richmond, Virginia and the surrounding 25,000 square feet of land, known as the Lee Monument, is state-owned property. The events at a "Unite the Right" rally on August 12, 2017, turned into a violent incident of civil unrest in Charlottesville, Virginia and necessitated a State of Emergency declaration by then Governor McAuliffe. Executive Order 67 followed on August 18, 2017, and required "full review of permitting processes and other relevant regulations." The executive order stated:

> Unlike a city park, the Lee Monument serves a limited purpose and has not historically been an open forum for expressive activity. It sits in a traffic rotary, in a major thoroughfare through the City of Richmond, in the middle of one of the most scenic and historic residential areas in the United States. Current standards contemplate up to 5,000 people gathering at the Lee Monument. Given the size of the Lee Monument, the fact that traffic continually passes around it, and that there is no pedestrian crosswalk for access, I have concluded that permitting any large group would create a safety hazard in the current circumstances. Current policies also allow for permits to be issued from sunrise to 11:00 pm, which also could, given the Lee Monument's proximity to private residences, interfere with the quiet enjoyment of those properties. Moreover, the Lee Monument is a State-property island in an area otherwise regulated by the City of Richmond, yet there is no formal requirement for coordinating approval through the City of Richmond's permitting process. This regulatory gap, which has heretofore been handled informally, must be addressed.

DGS promulgated emergency regulations on November 17, 2017. DGS now proposes to adopt those regulations permanently. One of the changes compared to the previous informal permit process is submission of more detailed information (e.g., a waste management plan, whether the event is being advertised, the type of the event, etc.) in addition to previously required information about the names and addresses of the group or organization, of its principal officers, and of the individual member responsible for the conduct of the event, etc. The submission and review of such additional information would likely add to the administrative costs that would be incurred by the applicant as well as by DGS. However, the additional information would also help DGS and the Division of Capitol Police determine staffing requirements to ensure public safety.

The proposed regulation also requires proof that all permit applications, including required road closure if necessary, have been submitted to the City of Richmond. Abutting streets around the monument are the property of the City of Richmond and subject to the city's permit rules. DGS may only consider approval of applications if the city has determined that no city permit is required, or if the required city permits have been issued. This requirement may add to the administrative costs of the City of Richmond, which would have to now evaluate each request and make a determination. For example, based on the publicly available City of Richmond criteria,[1] currently the City of Richmond may not require a permit for events where fewer than 300 people will participate, but this proposed regulation would require the applicant to obtain a formal determination from the city to that effect.

The proposed regulation has no bearing on the criteria the City of Richmond have in place or will have in the future. Therefore, the proposed regulation does not impose any additional burdens on applicants who would already have to obtain a permit from the city other than proving to DGS that such a permit is issued by the city. This proposed requirement would indirectly promote compliance with city permit rules. However, one unintended consequence could be that future event planners may be more inclined to limit attendance to fewer than 300 people and hold their events on the city-owned sidewalk surrounding the monument; therefore avoiding the need for any permits from the city or DGS.

The proposed regulation also reduces the maximum occupancy on the monument grounds from an established informal limit of 5,000 to 500 persons for the reasons stated in the executive order (i.e., limited size of the monument grounds, traffic in the surrounding area, lack of pedestrian crosswalk for access) to minimize safety hazards. Similarly, time limits are proposed to minimize traffic disruptions on a key thoroughfare and for the quiet enjoyment of surrounding private residences.[2] Finally, the proposed regulation establishes a list of prohibited items and activities (e.g., bricks, stones, alcohol, penetration of the ground, open burning, etc.) allowed during a permitted event. These proposed changes would limit the choices available to event planners compared to the previous informal permit process but are also expected to improve public safety during permitted events at the monument.

Businesses and Entities Affected. The proposed regulation would apply to applicants wishing to use Lee Monument grounds for special events. Events have been permitted and held at the Lee Monument in the past, including the Easter Parade and the Monument 10K. The Monument 10K should not be affected by the proposed regulation because the event has not sought a permit to specifically use the monument grounds in the last several years. The regulation may not apply to established events (i.e., events permitted in the past more than three consecutive years). For example, if Monument 10k were to apply for a permit, they may be grandfathered. An event may also be exempt from some of the proposed timing, duration, and prohibited item list at DGS's discretion based on this proposed regulation.

Localities Particularly Affected. The proposed regulation applies to a state-owned property in the City of Richmond.

Projected Impact on Employment. The proposed regulation would necessitate additional time to prepare and review an event application but is unlikely to have any discernible impact on employment.

Effects on the Use and Value of Private Property. The proposed regulation is expected to minimize disruption around the monument and would mitigate potential negative impacts during a few events but is unlikely to significantly affect the use and value of private property in that neighborhood.

Real Estate Development Costs. The proposed regulation is unlikely to affect real estate development costs.

Small Businesses:

Definition. Pursuant to § 2.2-4007.04 of the Code of Virginia, small business is defined as "a business entity, including its affiliates, that (i) is independently owned and operated and (ii) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million."

Costs and Other Effects. The proposed regulation is unlikely to impose costs and other impacts on small businesses.

Alternative Method that Minimizes Adverse Impact. The proposed regulation does not adversely affect small businesses.

Adverse Impacts:

Businesses: The proposed regulation does not adversely affect businesses.

Localities: The proposed regulation would introduce additional administrative costs on the City of Richmond, but

it may also strengthen compliance with the City of Richmond event permit rules by requiring proof of such a permit.

Other Entities: The proposed regulation imposes limits on time, duration, items allowed, and participation of and at events at the Lee Monument. Any entity wishing to hold an event under previous less stringent rules may perceive to be adversely affected.

[1]See http://eservices.ci.richmond.va.us/APPLICATIONS/SPECIALEVENTS/, accessed on Sept 6, 2018.

[2]Events may occur only Monday through Friday 9 a.m. to 4 p.m. and 7 p.m. to 9 p.m.; Saturday 9 a.m. to 9 p.m.; Sunday 2 p.m. to 9 p.m.

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

Summary:

The proposed action establishes the regulations for public use of the Robert E. Lee Monument located at 1700 Monument Avenue in the City of Richmond.

CHAPTER 150
REGULATIONS FOR PUBLIC USE OF ROBERT E. LEE MONUMENT, RICHMOND, VA

1VAC30-150-10. Purpose, applicability, and definitions.

The Robert E. Lee Monument, located at 1700 Monument Avenue, is the largest monument on the City of Richmond's Monument Avenue. The 60-foot high statue, composed of a granite base and 14-foot tall bronze equestrian statue of Robert E. Lee, stands in the middle of Lee Circle, a traffic circle at the intersection of Monument Avenue and Allen Avenue. The purpose of this chapter is to establish and codify regulations governing the use of this state-owned property. This chapter applies to the Lee Monument.

The following word or term when used in this chapter shall have the following meaning unless the context clearly indicates otherwise:

"Lee Monument" means the statue of Robert E. Lee and the surrounding 25,000 square feet of state-owned property located at 1700 Monument Avenue in the City of Richmond. The Lee Monument does not include the abutting sidewalk or streets, which are the property of the City of Richmond.

1VAC30-150-20. General rules.

The following rules apply to any person, including permit applicants and permit holders at the Lee Monument.

1. The Lee Monument shall be closed to the public from sunset each night until sunrise the following morning.

2. Any gathering that is expected to draw 10 or more participants requires a special event permit.

3. The maximum occupancy of the Lee Monument is 500 persons.

4. There shall be no motor vehicles on the Lee Monument at any time.

5. No banners, flags, posters, or other objects shall be placed on or affixed to the statue itself.

6. No persons shall climb on the statue itself. This provision also applies to the steps of the statue.

7. Unlawful activity is prohibited.

1VAC30-150-30. Rules regarding permitted events.

A. All permitted events must be coordinated with the City of Richmond to ensure that such event will not interfere with major vehicular traffic within the traffic circle. The areas surrounding the Lee Monument are residential zones. In conjunction with § 18.2-419 of the Code of Virginia and the City of Richmond's noise ordinance level restrictions, events at the grounds may only occur during the following hours, unless the times referenced in this subsection conflict with subdivision 1 of 1VAC30-150-20.

1. Monday through Friday: 9 a.m. to 4 p.m. and 7 p.m. to 9 p.m.

2. Saturday: 9 a.m. to 9 p.m.

3. Sunday: 2 p.m. to 9 p.m.

B. Permitted events may last a maximum of two hours, with an additional 30 minutes to set up and 30 minutes to break down the event. If the City of Richmond will require road closure, permitted events will be authorized to last one hour, with an additional 30 minutes to set up and 30 minutes to break down the event. Permitted events shall not exceed these time parameters.

C. The following items and activities are prohibited on the Lee Monument, and any violation will result in an immediate revocation of the permit and removal from the Lee Monument:

1. Weapons: any pistol, rifle, shotgun, or other firearm of any kind, whether loaded or unloaded, air rifle, air pistol, paintball gun, paintball rifle, explosive, blasting cap, knife, hatchet, ax, slingshot, blackjack, metal knuckles, mace, iron buckle, ax handle, chains, crowbar, hammer, or any club, bludgeon, or any other instrumentality used, or intended to be used, as a dangerous weapon.

2. Bricks, stones, rocks, or pieces of asphalt or concrete.

3. Glass bottles, glass jars, or glass containers of any kind.

4. Tents, tables, scaffolding, or staging.

5. Penetration of the ground by any object.

6. Stick-holding placards.

7. Solicitations, sales, collections, or fundraising activities.

8. Food, alcohol, or beverages of any type.

9. Auxiliary and portable lights.

10. Open air burning. Hand-held candles with drip guards are acceptable.

11. The use of unmanned aircraft systems (drones).

12. Hazardous, flammable, or combustible liquids or materials.

13. Animals, except service animals that are individually trained to do work or perform tasks for people with disabilities.

14. Fossil-fuel powered generators.

15. Any mask, hood, or other device whereby a substantial portion of the face is hidden or covered unless otherwise permitted by law.

D. Nothing in this chapter shall prohibit a disabled person from carrying, possessing, or using a wheelchair, cane, walker, or similar device necessary for providing mobility so that the person may participate in a permitted event.

E. Nothing in this chapter shall prohibit certified law-enforcement officers or other public safety officials acting in their official capacity from carrying or possessing materials, weapons, or devices used in the performance of law-enforcement duties.

F. Certain portions of subsections A, B, and C of this section may not apply to established events that have been approved for more than three consecutive years by the Department of General Services and the City of Richmond permitting processes prior to the enactment of this regulation.

1VAC30-150-40. Special event permit process.

A. Requests for a special event permit must be submitted in writing, on the forms required by the Department of General Services, and must be submitted to the Director of the Department of General Services at least 45 days prior to the requested event date.

B. All applications shall contain at a minimum, the following information:

1. Type and purpose of event, meeting, or function.

2. Name, address, telephone numbers, and email address of the applicant.

3. Name of the organization, date of origin, status (corporation, unincorporated association, partnership, nonprofit corporation, etc.), address, and telephone numbers. If applicable, the federal tax ID number, registered agent's address, telephone numbers, and email address.

4. Organization's primary point of contact, to include name, title, permanent address, telephone numbers, and email addresses.

5. Organization's primary and alternative point of contact who will be on-site at the Lee Monument for the event, to include name, address, telephone numbers, and email addresses. The organization's on-site primary point of contact shall be responsible for the conduct of participants at the event.

6. If the event is designed to be held by, on behalf of, or for any person other than the applicant, the applicant shall file with the director written documentation from the person or organization seeking to host the event, authorizing the applicant to apply for the permit on behalf of the person or organization.

7. The estimated number of participants for the event. The maximum occupancy for the Lee Monument is 500 persons.

8. Requested date and start and end times.

9. Whether the event is being advertised, to include advertising on social media platforms.

10. Proof that all needed permit applications have been submitted to the City of Richmond, to include a road closure permit if necessary. The applicant understands that if the City of Richmond will require road closure, authorized events will be permitted to last one hour, with an additional 30 minutes to set up and 30 minutes to break down the event. All events will begin at the agreed upon time and must fall within the allowable time periods addressed in this section.

11. List of requested items or equipment to be used during the event.

12. Waste management plan and a point of contact for the plan, including name and telephone number.

C. Notwithstanding the 45-day requirement for a special event permit, the applicant may apply for a permit for an event that is proposed to be conducted in less than six days, provided:

1.The applicant submits a completed special event permit application in accordance with this chapter.

2. A showing by the applicant, in writing, clearly describing why the circumstances giving rise to the proposed event did not reasonably allow the applicant to apply for a permit within the 45-day time period.

3. The event has not been planned for more than six days in advance of the proposed event.

4. Proof that all needed permit applications have been submitted to the City of Richmond, to include a road closure permit if necessary. The applicant understands that

if the City of Richmond will require road closure based on the size of the event, authorized events will be permitted to last one hour, with an additional 30 minutes to set up and 30 minutes to break down the event. All events will begin at the agreed upon time and must fall within the allowable time periods addressed in this section.

D. Permit applications may be submitted up to one year in advance of the proposed event.

E. The Director of the Department of General Services shall take action on all permit applications within 10 business days of receiving a complete special event permit application, and as soon as practicable but not more than three business days for applications submitted for events to be held within six business days. If no permits are required by the City of Richmond, the department shall approve or deny the application within 10 days. If one or more permits are required by the City of Richmond, the department shall acknowledge receipt of the application within 10 business days, but the Director of the Department of General Services shall not grant final approval until proof that all permits required by the city, to include a road closure permit, have been issued.

F. The Director of the Department of General Services shall deny a request for a permit if:

1. Another application has been previously submitted with a request for the same date and time;

2. Upon advisement from law enforcement, the director determines that approving the permit and allowing the event to occur would pose a significant threat to public safety;

3. Any of the conditions are not agreed to by the applicant;

4. The director concludes that the event could not possibly conform to the conditions prescribed in this chapter;

5. Any of the information contained in the application is found to be false or inaccurate; or

6. The City of Richmond denies a needed permit.

G. If a permit request is denied, the director shall send, in writing, an explanation of why the event permit was denied and if applicable, provide the applicant with alternative times or dates.

H. If a permit is denied due to a preexisting application for the same time and date, the director shall notify the applicant if the originally requested date and time become available.

I. Authorization for the use of the Lee Monument will be set forth in a letter addressed to the applicant.

J. The director or the director's designee may contact the applicant and the event organizer at any time to discuss or clarify the contents of the application or any additional conditions or restrictions to be applied.

1VAC30-150-50. Permit holder responsibilities.

A. The event organizer is responsible for providing a safe and secure event and may be required to provide general security, crowd control, and assistance to participants based on the size of the event. If general security is required by the Commonwealth, it shall be provided by law-enforcement personnel licensed by the Commonwealth of Virginia.

B. By submitting an application for a special event permit under this chapter, the applicant understands the following statements and conditions and agrees to comply with all rules, conditions, and restrictions:

1. The applicant agrees to all prohibitions and restrictions identified in this chapter;

2. The applicant and organization agree to indemnify the Commonwealth of Virginia against any loss or damage to the monument that may occur in connection with the applicant or event organizer's use of the property;

3. The applicant agrees to leave the premises clean and orderly.

4. The applicant and participants agree to obey all state and local laws and ordinances;

5. The applicant agrees to notify law enforcement, to include the Division of Capitol Police, if any unlawful activities occur during the permitted event. In addition to 9-1-1, the applicant should call the Capitol Police emergency number at (804) 786-4357. For nonemergencies, applicants should call (804) 786-2568;

6. Unlawful activities will be handled by law enforcement, to include the Division of Capitol Police; and

7. The applicant shall be required to notify the Director of the Department of General Services of any changes to the information contained in the permit application as soon as practicable.

C. Violations of this chapter shall result in immediate revocation of the permit by the Director of the Department of General Services or the director's designee, and in the event such revocation occurs, all participants shall be required to immediately vacate the monument. Failure of any person to immediately vacate the monument after proper notice shall be considered trespassing in violation of § 18.2-119 of the Code of Virginia.

NOTICE: Forms used in administering the regulation have been filed by the agency. The form is 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 form is also available from the agency contact or may be viewed at the Office of the Registrar of Regulations, 900 East Main Street, 11th Floor, Richmond, Virginia 23219.

FORMS (1VAC30-150)

Request to Hold an Event at the Lee Monument (undated, filed 12/19/2018)

VA.R. Doc. No. R18-5342; Filed December 12, 2018, 9:29 a.m.

TITLE 8. EDUCATION

BOARD OF VISITORS OF THE COLLEGE OF WILLIAM AND MARY

Final Regulation

REGISTRAR'S NOTICE: The Board of Visitors of the College of William and Mary is claiming an exemption from the Administrative Process Act in accordance with § 2.2-4002 A 6 of the Code of Virginia, which exempts educational institutions operated by the Commonwealth.

Title of Regulation: **8VAC115-30. Richard Bland College Weapons on Campus Regulation (amending 8VAC115-30-10, 8VAC115-30-20, 8VAC115-30-30).**

Statutory Authority: § 23.1-1301 of the Code of Virginia.

Effective Date: January 2, 2019.

Agency Contact: Carla Costello, ADA Coordinator and Compliance Investigator, College of William and Mary, 108 James Blair Hall, Williamsburg, VA 23185, telephone (757) 221-1254, or email cacostello@wm.edu.

Summary:

The amendments refine the definition of "weapon" and clarify the applicability of the regulation.

8VAC115-30-10. Definitions.

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

"College property" means any property, vehicle, or vessel owned, leased, or controlled by Richard Bland College ~~of the College of William and Mary~~.

"Police officer" means law-enforcement officials appointed pursuant to Article 3 (§ 15.2-1609 et seq.) of Chapter 16 and Chapter 17 (§ 15.2-1700 et seq.) of Title 15.2, Article 3 (§ 23.1-809 et seq.) of Chapter ~~17 (§ 23-232 et seq.)~~ 8 of Title ~~23~~ 23.1, Chapter 2 (§ 29.1-200 et seq.) of Title 29.1, or Chapter 1 (§ 52-1 et seq.) of Title 52 of the Code of Virginia or sworn federal law-enforcement officers.

"Weapon" means any ~~firearm~~ instrument of combat or any object not designed as an instrument of combat but carried for the apparent purpose of inflicting or threatening bodily injury. Examples include:

1. Firearms, including any pistol, revolver, rifle, shotgun, air-pistol, paintball gun, or other weapon designed or intended to propel a bullet, cartridge, or missile of any kind by action of an explosion of any combustible material;

2. Knives, including any dirk, bowie knife, switchblade knife, ballistic knife, butterfly knife, sword, machete, razor, spring stick, or other bladed weapon with a blade longer than four inches;

3. Razors or metal knuckles;

4. Blackjacks, foils, or hatchets;

5. Bows and arrows, crossbows, or slingshots;

6. Nun chahkas, including any flailing instrument consisting of two or more rigid parts connected in such a manner as to allow them to swing freely, which may also be known as a nun chuck, nunchaku, shuriken, or fighting chain;

7. Throwing stars, including any disc, of whatever configuration, having at least two points or pointed blades, which is designed to be thrown or propelled and which may be known as an oriental dart;

8. Stun guns, including any device that emits a momentary or pulsed output that is electrical, audible, optical, or electromagnetic in nature and that is designed to temporarily incapacitate a person;

9. Any explosive or incendiary device, including fireworks or other devices relying on any combination of explosives and combustibles to be set off to generate lights, smoke, or noise; or

10. Any other weapon listed in § 18.2-308 A of the Code of Virginia.

"Weapon" does not include (i) knives or razors commonly used for domestic or academic purposes or pen or folding knives with blades less than three inches in length or (ii) mace, pepper spray, and other such items possessed, stored, or carried for use in accordance with the purpose intended by the original manufacturer.

8VAC115-30-20. Possession of weapons prohibited; exceptions.

A. Possession, storing, or carrying of any weapon by any person~~, except a police officer or an individual authorized pursuant to college policy,~~ is prohibited on college property, whether in ~~academic buildings, administrative buildings, student residence and student life buildings, or dining or athletic facilities, or while attending an official college event, such as~~ any college building; while attending an athletic, academic, social, recreational, or educational event~~,~~; or on vehicles or vessels that are college property. This prohibition also applies to all events or activities on college property where people congregate in any public or outdoor areas.

B. This prohibition does not apply to:

1. Police officers on college property in an official capacity pursuant to a college request, mutual aid agreement, or on active duty and within their jurisdiction; or

2. A college employee possessing, storing, or carrying a weapon as expressly authorized or required by the terms of the college employment.

C. Entry upon such college property in violation of this prohibition is expressly forbidden. Persons violating this prohibition will be asked to remove the weapon immediately from college property. Failure to comply with this request may result in arrest for trespass. Members of the college community are also subject to disciplinary action.

8VAC115-30-30. Person lawfully in charge.

In addition to individuals authorized by college policy or job duties, Richard Bland College police officers are lawfully in charge for the purposes of forbidding entry upon or remaining upon college property while possessing or carrying weapons in violation of this prohibition.

VA.R. Doc. No. R19-5783; Filed December 18, 2018, 4:18 p.m.

Final Regulation

REGISTRAR'S NOTICE: The Board of Visitors of the College of William and Mary is claiming an exemption from the Administrative Process Act in accordance with § 2.2-4002 A 6 of the Code of Virginia, which exempts educational institutions operated by the Commonwealth.

Title of Regulation: **8VAC115-50. Richard Bland College Open Flames on Campus (adding 8VAC115-50-10 through 8VAC115-50-50).**

Statutory Authority: § 23.1-1301 of the Code of Virginia.

Effective Date: January 2, 2019.

Agency Contact: Carla Costello, ADA Coordinator and Compliance Investigator, College of William and Mary, 108 James Blair Hall, Williamsburg, VA 23185, telephone (757) 221-1254, or email cacostello@wm.edu.

Summary:

The regulation establishes the limitations on the presence of open flames in college buildings or on college property and imposes the requirement for a permit for certain activities involving open burning or open flames.

CHAPTER 50
RICHARD BLAND COLLEGE OPEN FLAMES ON CAMPUS

8VAC115-50-10. Definitions.

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

"Open flame" means any activity or device producing a flame, including candles, tiki torches, oil lanterns, butane or other gas burners, incense, campfires, bonfires, fire pits, and grills.

"College property" means any property, vehicle, or vessel owned, leased, or controlled by Richard Bland College.

8VAC115-50-20. Permit required for open burning and open flames; exceptions.

A. Open flames are prohibited on all college property, including within college buildings and facilities, except pursuant to a permit issued by the college's Department of Campus Safety and Police.

B. Exceptions to the requirement for a permit are:

1. Activities taking place within the scope of academic coursework when under the supervision of the relevant faculty member;

2. Flames created for the transient purpose of lighting a cigarette, cigar, pipe, or similar smoking device, provided such activity is in an authorized location and is otherwise lawful, and the burning or smoking elements are safely and responsibly disposed;

3. Small celebration candles used briefly and in an appropriate quantity in connection with a celebration, provided such activity is not left unattended, is in an authorized location and is otherwise lawful, and the smoking or burning elements are safely and responsibly disposed; and

4. Activities undertaken by college contractors whose contract has been approved by the President of Richard Bland college or the president's designee and which contract authorizes open flames.

8VAC115-50-30. Permits.

A. Persons seeking to ignite an open flame must apply to the Department of Campus Safety and Police for a permit to perform the activity. Permits may be issued for a one-time event or activity or on a recurring or ongoing basis.

B. Applicants must apply at least five working days in advance of the activity to ensure consideration. An applicant's history of compliance with previous permits will be considered in a decision to grant a permit.

C. Persons granted permits are required to comply with all conditions of the permit.

8VAC115-50-40. Person lawfully in charge.

In addition to individuals authorized by college policy, Richard Bland College police officers and representatives of the Department of Campus Safety and Police are lawfully in charge for the purposes of forbidding entry upon or remaining

upon college property of those who are in violation of this prohibition.

8VAC115-50-50. Compliance with policy.

Persons who fail to obtain a permit or to comply with its conditions will be asked to extinguish the open flame or bring the activity into compliance with the terms of the permit. Failure to comply may result in a request to leave campus. Failure to leave campus may result in arrest for trespass. Members of the campus community are also subject to disciplinary action, including termination or expulsion.

VA.R. Doc. No. R19-5782; Filed December 18, 2018, 4:19 p.m.

TITLE 11. GAMING

VIRGINIA RACING COMMISSION

Final Regulation

REGISTRAR'S NOTICE: The Virginia Racing Commission is claiming an exemption from the Administrative Process Act pursuant to § 2.2-4002 A 17 of the Code of Virginia, which exempts the commission when promulgating technical regulations regarding actual live horse racing at race meetings licensed by the commission. The commission is also claiming an exemption from the Administrative Process Act pursuant to § 2.2-4002 B 12 of the Code of Virginia, which exempts agency action relating to instructions for application or renewal of a license, certificate, or registration required by law.

Title of Regulation: **11VAC10-60. Participants (amending 11VAC10-60-15).**

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

Effective Date: January 1, 2019.

Agency Contact: Kimberly Mackey, Regulatory Coordinator, Virginia Racing Commission, 5707 Huntsman Road, Suite 201-B, Richmond, VA 23250, telephone (804) 966-7406, or email kimberly.mackey@vrc.virginia.gov.

Summary:

The amendments reduce the permit fees associated with participants involved in live horseracing to the same amount charged for licensee employees.

11VAC10-60-15. Fee schedule for permit holders.

Type of Permit	Fee
Apprentice Jockey	~~$50~~ $25
Assistant General Manager	$25
Assistant Racing Secretary	$25
Assistant Starter	$25
Assistant Trainer	~~$50~~ $25
Authorized Agent	~~$50~~ $25
Claims Clerk	$25
Clerk of Scales	$25
Clerk of the Course	$25
Clocker	$25
Concessionaire/Vendor	$25
Concessionaire/Vendor Employee	$25
Custodian of Jockeys' Room	$25
Director of Security	$25
Driver	~~$50~~ $25
Entry Clerk	$25
Exercise Rider	$25
Farrier	~~$50~~ $25
Foreman	~~$50~~ $25
Gap Attendant	$25
General Manager	$25
Groom/Hotwalker	~~$25~~ $10
Horse Identifier	$25
Horsemen's Bookkeeper	$25
Horse Owner	~~$50~~ $25
Jockey	~~$50~~ $25
Jockey Agent	~~$50~~ $25
Licensee-Administrative Employee	$25
Licensee-Marketing Employee	$25
Licensee-Medical Employee	$25
Licensee-Operations Employee	$25
Licensee-Plant Employee	$25
Licensee-Staff Employee	$25
Mutuel Clerk	$25
Mutuel Manager	$25
Outrider	$25
Paddock Judge	$25
Patrol Judge	$25

Photo-Finish Camera Operator	$25
Placing Judge	$25
Pony Rider	$25
Program Director	$25
Racing Secretary	$25
Security Officer	$25
Stable Name	$25
Stall Superintendent	$25
Starter	$25
Timer	$25
Track Superintendent	$25
Trainer	~~$50~~ $25
Trainer/Driver (Harness Racing)	~~$50~~ $25
Valet	$25
Veterinarian (Licensee)	$25
Veterinarian (Private Practice)	~~$50~~ $25
Video Patrol Personnel	$25

VA.R. Doc. No. R19-5766; Filed December 17, 2018, 12:30 p.m.

TITLE 12. HEALTH

STATE BOARD OF HEALTH

Final Regulation

Title of Regulation: **12VAC5-490. Virginia Radiation Protection Regulations: Fee Schedule (amending 12VAC5-490-10, 12VAC5-490-20, 12VAC5-490-40).**

Statutory Authority: § 32.1-229.1 of the Code of Virginia.

Effective Date: February 7, 2019.

Agency Contact: Steve Harrison, Director, Division of Radiological Health, Virginia Department of Health, 109 Governor Street, Richmond, VA 23219, telephone (804) 864-8151, FAX (804) 864-8155, or email steve.harrison@vdh.virginia.gov.

Summary:

The amendments increase fees in the fee schedule used by the X-Ray Program for device registrations and inspections and in the fee schedule used by the Radioactive Materials Program for charging annual licensing fees to maintain program solvency and provide adequate regulatory controls.

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

12VAC5-490-10. Registration fees.

A. All operators or owners of diagnostic x-ray machines used in the healing arts and capable of producing radiation shall pay the following registration fee:

1. ~~$50~~ $100 for each machine and additional ~~tube(s)~~ tubes that have a required annual inspection, collected annually; and

2. ~~$60~~ $100 for each machine and additional ~~tube(s)~~ tubes that have a required inspection every three years, collected every three years.

B. All operators or owners of therapeutic x-ray, particle accelerators, and teletherapy machines used in the healing arts capable of producing radiation shall pay the following annual registration fee:

1. ~~$50~~ $100 for each machine with a maximum beam energy of less than 500 KVp;

2. ~~$50~~ $100 for each machine with a maximum beam energy of 500 KVp or greater.

C. All operators or owners of baggage, cabinet or analytical, or industrial x-ray machines capable of producing radiation shall pay the following annual registration fee:

1. ~~$20~~ $40 for each machine used for baggage inspection;

2. ~~$25~~ $50 for each machine identified as cabinet or analytical; and

3. ~~$50~~ $100 for each machine used for industrial radiography.

D. Where the operator or owner of the aforementioned machines is a state agency or local government, that agency is exempt from the payment of the registration fee.

12VAC5-490-20. Inspection fees and inspection frequencies for x-ray machines.

The following table lists the fees that shall be charged for surveys requested by the registrant and performed by a Department of Health inspector, as well as the required inspection frequencies for each type of x-ray machine:

Type	Cost Per Tube	Inspection Frequency
General Radiographic (includes: Chiropractic and Special Purpose X-ray Systems)	~~$230~~ $250	Annually
Fluoroscopic, C-arm Fluoroscopic	~~$230~~ $250	Annually

Combination (General Purpose-Fluoroscopic)	~~$460~~ $500	Annually
Dental Intraoral and Panographic	~~$90~~ $100	Every 3 years
Veterinary	~~$160~~ $175	Every 3 years
Podiatric	~~$90~~ $125	Every 3 years
Cephalometric	~~$120~~ $130	Every 3 years
Bone Densitometry	~~$90~~ $100	Every 3 years
Combination (Dental Panographic and Cephalometric)	~~$210~~ $230	Every 3 years
Shielding Review for Dental Facilities	~~$250~~ $300	Initial/Prior to use
Shielding Review for Radiographic, Chiropractic, Veterinary, Fluoroscopic, or Podiatric Facilities	~~$450~~ $500	Initial/Prior to use
Baggage X-ray Unit	$100	Every 5 years
Cabinet or Analytical X-ray Unit	$150	Every 3 years
Industrial Radiography X-ray Unit	$200	Annually

12VAC5-490-40. Application and licensing fees for radioactive materials licenses.

The application fee for a radioactive materials license and annual fees for persons issued a radioactive materials license pursuant to 12VAC5-481 are listed in the following table:

Category		Specific License Type	Application & Annual Fee
1		Special Nuclear Material (SNM)	
	A.	Possession and use of SNM in sealed sources contained in devices used in measuring systems	~~$1,000~~ $1,700
	B.	SNM to be used as calibration and reference sources	~~$500~~ $900
	C.	SNM - all other, except license authorizing SNM in unsealed form that would constitute a critical mass (fee waived if facility holds additional license category)	~~$2,000~~ $3,400
2		Source Material	
	A.	Source material processing and distribution	~~$3,000~~ $5,100
	B.	Source material in shielding (fee waived if facility holds additional license category)	~~$200~~ $300
	C.	Source material - all other, excluding depleted uranium used as shielding or counterweights	~~$2,000~~ $3,400
3		Byproduct, NARM	
	A.	Broad scope for processing or manufacturing of items for commercial distribution	~~$10,000~~ $17,000
	B.	Processing or manufacturing and commercial distribution of radiopharmaceuticals, generators, reagent kits and sources or devices	~~$6,000~~ $9,000
	C.	Commercial distribution or redistribution of radiopharmaceuticals, generators, reagent kits and sources or devices	~~$4,000~~ $6,800
	D.	Processing or manufacturing of items for commercial distribution	~~$2,000~~ $3,400
	E.	Industrial radiography operations performed only in a shielded radiography installation	~~$3,000~~ $5,100
	F.	Industrial radiography performed only at the address indicated on the license~~,~~ and at temporary job sites	~~$3,500~~ $6,000
	G.	Possession and use of less than 370 TBq (10,000 curies) of radioactive material in sealed sources for irradiation of materials where the source is not removed from the shield (fee waived if facility holds additional irradiator license category)	~~$2,000~~ $3,400

	H.	Possession and use of less than 370 TBq (10,000 curies) of radioactive material in sealed sources for irradiation of materials where the source is exposed for irradiation purposes. The category also includes underwater irradiators for irradiation of materials in which the source is not exposed for irradiation	~~$3,000~~ $5,100
	I.	Possession and use of at least 370 TBq (10,000 curies) and less than 3.7 PBq (100,000 curies) of radioactive material in sealed sources for irradiation of materials~~)~~	~~$3,000~~ $5,100
	J.	Possession and use of 3.7 PBq (100,000 curies) or more of radioactive material in sealed sources for irradiation of materials	~~$5,000~~ $8,500
	K.	Distribute items containing radioactive materials to persons under a general license	~~$1,000~~ $1,700
	L.	Possess radioactive materials intended for distribution to persons exempt from licensing	~~$1,000~~ $1,700
	M.	Broad scope for research and development that does not authorize commercial distribution	~~$6,000~~ $10,200
	N.	Research and development that does not authorize commercial distribution	~~$1,000~~ $1,700
	O.	Installation, repair, maintenance or other service of devices or items containing radioactive material, excluding waste transportation or broker services	~~$1,000~~ $1,700
	P.	Portable gauges	~~$750~~ $1,300
	Q.	Portable ~~X-ray~~ x-ray fluorescence analyzer (XRF), dewpointer or gas chromatograph	~~$250~~ $400
	R.	Leak testing services	~~$500~~ $900
	S.	Instrument calibration services	~~$1,000~~ $1,700
	T.	Fixed gauges	~~$750~~ $1,300
	U.	All other radioactive material licenses, except as otherwise noted	~~$1,500~~ $2,600
4		Waste Processing	
	A.	Commercial waste treatment facilities, including incineration	~~$100,000~~ $170,000
	B.	All other commercial facilities involving waste compaction, repackaging, storage or transfer	~~$7,500~~ $12,800
	C.	Waste processing - all other, including decontamination service	~~$5,000~~ $8,500
5		Well Logging	
	A.	Well logging using sealed sources or subsurface tracer studies	~~$3,000~~ $5,100
	B.	Well logging using sealed sources and subsurface tracer studies	~~$3,000~~ $5,100
6		Nuclear Laundry	
	A.	Commercial collection and laundry of items contaminated with radioactive material	~~$10,000~~ $17,000
7		~~Medical/Veterinary~~ Medical or veterinary	
	A.	Human use of sealed sources contained in teletherapy or stereotactic radiosurgery devices, including mobile therapy	~~$6,000~~ $10,200
	B.	Broad scope for human use in medical diagnosis, treatment, research and development (excluding teletherapy or stereotactic radiosurgery devices)	~~$12,000~~ $20,400
	C.	Mobile nuclear medicine	~~$2,000~~ $3,400
	D.	Medical institutions providing imaging, diagnostic or radionuclide therapy	~~$2,300~~ $4,000

	E.	Medical institutions using a High Dose Remote Afterloader (HDR) or emerging technologies	~~$3,750~~ $6,400
	F.	Veterinary use of radioactive materials	~~$1,000~~ $1,700
	G.	In-vitro	~~$1,000~~ $1,700
8		Academic	
	A.	Educational use or academic research and development that does not authorize commercial distribution, excluding broad scope or human use licenses	~~$750~~ $1,300
9		Accelerator	
	A.	Production of radioisotopes with commercial distribution	~~$2,000~~ $3,400
	B.	Production - all other (fee waived if facility holds medical broad scope license with no commercial distribution)	~~$2,000~~ $3,400
10		Reciprocity	
	A.	Reciprocity recognition of an out-of-state specific license	50% of annual fee of applicable category

VA.R. Doc. No. R17-5115; Filed December 13, 2018, 9:33 a.m.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Fast-Track Regulation

Titles of Regulations: **12VAC30-50. Amount, Duration, and Scope of Medical and Remedial Care Services (amending 12VAC30-50-130, 12VAC30-50-226).**

12VAC30-130. Amount, Duration, and Scope of Selected Services (amending 12VAC30-130-5170, 12VAC30-130-5190).

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

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: February 6, 2019.

Effective Date: February 21, 2019.

Agency Contact: Emily McClellan, Regulatory Supervisor, Policy Division, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-4300, FAX (804) 786-1680, or email emily.mcclellan@dmas.virginia.gov.

Basis: Section 32.1-325 of the Code of Virginia grants the Board of Medical Assistance Services the authority to administer and amend the State Plan for Medical Assistance. Section 32.1-324 of the Code of Virginia authorizes the Director of the Department of Medical Assistance Services (DMAS) to administer and amend the State Plan for Medical Assistance according to the board's requirements. The Medicaid authority as established by § 1902(a) of the Social Security Act (42 USC § 1396a) provides governing authority for payments for services.

Purpose: The purpose of this action is to replace incorrect citations with either correct citations or text and remove an annual caseload limit for peer support specialists. This action protects the public health, safety, and welfare by updating the regulations related to peer support services to ensure that internal cross-references are correct and to remove a caseload limit that was determined to be a barrier to receiving peer support services. Peer support services are an important component of the spectrum of mental health and substance use disorder services, and it is essential to maintain correct regulations so that Medicaid can continue to offer this treatment.

Rationale for Using Fast-Track Rulemaking Process: This regulatory action is being promulgated as a fast-track rulemaking action because it is expected to be noncontroversial. The citation corrections do not have any impact on providers or Medicaid members. Medicaid providers requested the removal of the annual caseload limit, and this change will not impact Medicaid members.

Substance: Providers of peer support services have found that some Medicaid members seek services but do not follow through on receiving services. Those individuals are counted toward the provider's annual caseload, and the annual limit of 30 to 40 individuals means that providers cannot offer services to individuals who do wish to follow through with services. Therefore, the annual caseload requirement has been removed. The caseload limit of 12 to 15 individuals at any one time remains in place.

This regulatory action corrects citations. In one instance, a citation has been replaced by the medical necessity criteria text for continued services rather than providing a citation for the requirements for continued services.

Issues: The primary advantages to the Commonwealth and the public from these regulatory changes are that they remove incorrect citations so that the regulations contain accurate cross-references. In addition, removing the problematic annual caseload limit while maintaining the limit on cases

open at any given time ensures that providers are available to offer services to individuals who are seeking them while at the same time ensuring that providers can spend adequate time with each individual. There are no disadvantages to the Commonwealth or the public as a result of this regulatory action.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The Board of Medical Assistance Services (Board) proposes to remove the annual caseload limit for peer recovery specialists.

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

Estimated Economic Impact. Currently, providers are not allowed to assign more than 12 to 15 cases to one full-time peer recovery specialist any one time and 30 to 40 individuals annually. Similarly, part-time specialists may not be assigned more than 6 to 9 individuals at the same time and more than 15 individuals annually. DMAS has been made aware that many individuals initiate the service but later fail to follow up. In such cases, the annual limit becomes a barrier to serve 12 to 15 cases by a full-time specialist and 6 to 9 by a part-time specialist. As a result, the Board is proposing to remove the annual limits. The maximum number of individuals who can be served by one specialist at one time (i.e., 15 cases for full-time and 9 cases for part-time specialists) will remain intact.

On a monthly basis, 214 recipients use the service at a cost of $1,709 or $7.99 per member, per month. The removal of the annual limit will likely cause an increase in access to this service and associated expenditures, but any such increase is not likely to be large given the low number of individuals utilizing the service and the low unit costs.

Businesses and Entities Affected. As of January 2018, there were 33 peer providers and approximately 214 recipients per month receiving this service.

Localities Particularly Affected. The proposed regulation does not disproportionately affect particular localities.

Projected Impact on Employment. Removing the limit on annual caseloads should have a positive impact on the supply of professional peer services and could have a small positive effect on employment.

Effects on the Use and Value of Private Property. This change will allow providers to assign cases to their specialists up to the caseload limit that remains intact, which should have a positive impact on their asset values.

Real Estate Development Costs. The proposed regulation does not affect real estate development costs.

Small Businesses:

Definition. Pursuant to § 2.2-4007.04 of the Code of Virginia, small business is defined as "a business entity, including its affiliates, that (i) is independently owned and operated and (ii) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million."

Costs and Other Effects. Many of the affected peer providers are likely to be small businesses. The proposed regulation will allow them to assign more cases to the specialists working for them.

Alternative Method that Minimizes Adverse Impact. The proposed regulation does not adversely affect small businesses.

Adverse Impacts:

Businesses. The proposed regulation does not adversely affect businesses.

Localities. The proposed regulation does not adversely affect localities.

Other Entities. The proposed regulation would cause a slight increase in Medicaid expenditures.

Agency's Response to Economic Impact Analysis: The agency has reviewed the economic impact analysis prepared by the Department of Planning and Budget and raises no issues with this analysis.

Summary:

The amendments (i) remove an annual caseload limit for peer support specialists that was found to be a barrier to individuals receiving peer support services but leave a limit for the number of individuals in a peer support specialist's care at any one time and (ii) correct citations.

12VAC30-50-130. Nursing facility services, EPSDT, including school health services and family planning.

A. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older. Service must be ordered or prescribed and directed or performed within the scope of a license of the practitioner of the healing arts.

B. Early and periodic screening and diagnosis of individuals younger than 21 years of age, and treatment of conditions found.

1. Payment of medical assistance services shall be made on behalf of individuals younger than 21 years of age, who are Medicaid eligible, for medically necessary stays in acute care facilities, and the accompanying attendant physician care, in excess of 21 days per admission when such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a physical examination.

2. Routine physicals and immunizations (except as provided through EPSDT) are not covered except that well-child examinations in a private physician's office are covered for foster children of the local social services departments on specific referral from those departments.

3. Orthoptics services shall only be reimbursed if medically necessary to correct a visual defect identified by an EPSDT examination or evaluation. The department shall place appropriate utilization controls upon this service.

4. Consistent with the Omnibus Budget Reconciliation Act of 1989 § 6403, early and periodic screening, diagnostic, and treatment services means the following services: screening services, vision services, dental services, hearing services, and such other necessary health care, diagnostic services, treatment, and other measures described in Social Security Act § 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services and that are medically necessary, whether or not such services are covered under the State Plan and notwithstanding the limitations, applicable to recipients ages 21 years and older, provided for by § 1905(a) of the Social Security Act.

5. Community mental health services. These services in order to be covered (i) shall meet medical necessity criteria based upon diagnoses made by LMHPs who are practicing within the scope of their licenses and (ii) are reflected in provider records and on providers' claims for services by recognized diagnosis codes that support and are consistent with the requested professional services.

a. Definitions. The following words and terms when used in this section shall have the following meanings unless the context clearly indicates otherwise:

"Activities of daily living" means personal care activities and includes bathing, dressing, transferring, toileting, feeding, and eating.

"Adolescent or child" means the individual receiving the services described in this section. For the purpose of the use of these terms, adolescent means an individual 12 through 20 years of age; a child means an individual from birth up to 12 years of age.

"Behavioral health service" means the same as defined in 12VAC30-130-5160.

"Behavioral health services administrator" or "BHSA" means an entity that manages or directs a behavioral health benefits program under contract with DMAS.

"Care coordination" means collaboration and sharing of information among health care providers, who are involved with an individual's health care, to improve the care.

"Caregiver" means the same as defined in 12VAC30-130-5160.

"Certified prescreener" means an employee of the local community services board or behavioral health authority, or its designee, who is skilled in the assessment and treatment of mental illness and has completed a certification program approved by the Department of Behavioral Health and Developmental Services.

"Clinical experience" means providing direct behavioral health services on a full-time basis or equivalent hours of part-time work to children and adolescents who have diagnoses of mental illness and includes supervised internships, supervised practicums, and supervised field experience for the purpose of Medicaid reimbursement of (i) intensive in-home services, (ii) day treatment for children and adolescents, (iii) community-based residential services for children and adolescents who are younger than 21 years of age (Level A), or (iv) therapeutic behavioral services (Level B). Experience shall not include unsupervised internships, unsupervised practicums, and unsupervised field experience. The equivalency of part-time hours to full-time hours for the purpose of this requirement shall be as established by DBHDS in the document entitled Human Services and Related Fields Approved Degrees/Experience, issued March 12, 2013, revised May 3, 2013.

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

"Direct supervisor" means the person who provides direct supervision to the peer recovery specialist. The direct supervisor (i) shall have two consecutive years of documented practical experience rendering peer support services or family support services, have certification training as a PRS under a certifying body approved by DBHDS, and have documented completion of the DBHDS PRS supervisor training; (ii) shall be a qualified mental health professional (QMHP-A, QMHP-C, or QMHP-E) as defined in 12VAC35-105-20 with at least two consecutive years of documented experience as a QMHP, and who has documented completion of the DBHDS PRS supervisor training; or (iii) shall be an LMHP who has documented completion of the DBHDS PRS supervisor training who is acting within his scope of practice under state law. An LMHP providing services before April 1, 2018, shall have until April 1, 2018, to complete the DBHDS PRS supervisor training.

"DMAS" means the Department of Medical Assistance Services and its contractors.

"EPSDT" means early and periodic screening, diagnosis, and treatment.

"Family support partners" means the same as defined in 12VAC30-130-5170.

"Human services field" means the same as the term is defined by DBHDS in the document entitled Human Services and Related Fields Approved Degrees/Experience, issued March 12, 2013, revised May 3, 2013.

"Individual service plan" or "ISP" means the same as the term is defined in 12VAC30-50-226.

"Licensed mental health professional" or "LMHP" means the same as defined in 12VAC35-105-20.

"LMHP-resident" or "LMHP-R" means the same as "resident" as defined in (i) 18VAC115-20-10 for licensed professional counselors; (ii) 18VAC115-50-10 for licensed marriage and family therapists; or (iii) 18VAC115-60-10 for licensed substance abuse treatment practitioners. An LMHP-resident shall be in continuous compliance with the regulatory requirements of the applicable counseling profession for supervised practice and shall not perform the functions of the LMHP-R or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Counseling. For purposes of Medicaid reimbursement to their supervisors for services provided by such residents, they shall use the title "Resident" in connection with the applicable profession after their signatures to indicate such status.

"LMHP-resident in psychology" or "LMHP-RP" means the same as an individual in a residency, as that term is defined in 18VAC125-20-10, program for clinical psychologists. An LMHP-resident in psychology shall be in continuous compliance with the regulatory requirements for supervised experience as found in 18VAC125-20-65 and shall not perform the functions of the LMHP-RP or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Psychology. For purposes of Medicaid reimbursement by supervisors for services provided by such residents, they shall use the title "Resident in Psychology" after their signatures to indicate such status.

"LMHP-supervisee in social work," "LMHP-supervisee," or "LMHP-S" means the same as "supervisee" as defined in 18VAC140-20-10 for licensed clinical social workers. An LMHP-supervisee in social work shall be in continuous compliance with the regulatory requirements for supervised practice as found in 18VAC140-20-50 and shall not perform the functions of the LMHP-S or be considered a "supervisee" until the supervision for specific clinical duties at a specific site is preapproved in writing by the Virginia Board of Social Work. For purposes of Medicaid reimbursement to their supervisors for services provided by supervisees, these persons shall use the title "Supervisee in Social Work" after their signatures to indicate such status.

"Peer recovery specialist" or "PRS" means the same as defined in 12VAC30-130-5160.

"Person centered" means the same as defined in 12VAC30-130-5160.

"Progress notes" means individual-specific documentation that contains the unique differences particular to the individual's circumstances, treatment, and progress that is also signed and contemporaneously dated by the provider's professional staff who have prepared the notes. Individualized and member-specific progress notes are part of the minimum documentation requirements and shall convey the individual's status, staff interventions, and, as appropriate, the individual's progress, or lack of progress, toward goals and objectives in the ISP. The progress notes shall also include, at a minimum, the name of the service rendered, the date of the service rendered, the signature and credentials of the person who rendered the service, the setting in which the service was rendered, and the amount of time or units/hours required to deliver the service. The content of each progress note shall corroborate the time/units billed. Progress notes shall be documented for each service that is billed.

"Psychoeducation" means (i) a specific form of education aimed at helping individuals who have mental illness and their family members or caregivers to access clear and concise information about mental illness and (ii) a way of accessing and learning strategies to deal with mental illness and its effects in order to design effective treatment plans and strategies.

"Psychoeducational activities" means systematic interventions based on supportive and cognitive behavior therapy that emphasizes an individual's and his family's needs and focuses on increasing the individual's and family's knowledge about mental disorders, adjusting to mental illness, communicating and facilitating problem solving and increasing coping skills.

"Qualified mental health professional-child" or "QMHP-C" means the same as the term is defined in 12VAC35-105-20.

"Qualified mental health professional-eligible" or "QMHP-E" means the same as the term is defined in 12VAC35-105-20 and consistent with the requirements of 12VAC35-105-590.

"Qualified paraprofessional in mental health" or "QPPMH" means the same as the term is defined in 12VAC35-105-20 and consistent with the requirements of 12VAC35-105-1370.

"Recovery-oriented services" means the same as defined in 12VAC30-130-5160.

"Recovery, resiliency, and wellness plan" means the same as defined in 12VAC30-130-5160.

"Resiliency" means the same as defined in 12VAC30-130-5160.

"Self-advocacy" means the same as defined in 12VAC30-130-5160.

"Service-specific provider intake" means the face-to-face interaction in which the provider obtains information from the child or adolescent, and parent or other family member, as appropriate, about the child's or adolescent's mental health status. It includes documented history of the severity, intensity, and duration of mental health care problems and issues and shall contain all of the following elements: (i) the presenting issue/reason for referral, (ii) mental health history/hospitalizations, (iii) previous interventions by providers and timeframes and response to treatment, (iv) medical profile, (v) developmental history including history of abuse, if appropriate, (vi) educational/vocational status, (vii) current living situation and family history and relationships, (viii) legal status, (ix) drug and alcohol profile, (x) resources and strengths, (xi) mental status exam and profile, (xii) diagnosis, (xiii) professional summary and clinical formulation, (xiv) recommended care and treatment goals, and (xv) the dated signature of the LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP.

"Services provided under arrangement" means the same as defined in 12VAC30-130-850.

"Strength-based" means the same as defined in 12VAC30-130-5160.

"Supervision" means the same as defined in 12VAC30-130-5160.

b. Intensive in-home services (IIH) to children and adolescents younger than 21 years of age shall be time-limited interventions provided in the individual's residence and when clinically necessary in community settings. All interventions and the settings of the intervention shall be defined in the Individual Service Plan. All IIH services shall be designed to specifically improve family dynamics, provide modeling, and the clinically necessary interventions that increase functional and therapeutic interpersonal relations between family members in the home. IIH services are designed to promote psychoeducational benefits in the home setting of an individual who is at risk of being moved into an out-of-home placement or who is being transitioned to home from an out-of-home placement due to a documented medical need of the individual. These services provide crisis treatment; individual and family counseling; communication skills (e.g., counseling to assist the individual and his parents or guardians, as appropriate, to understand and practice appropriate problem solving, anger management, and interpersonal interaction, etc.); care coordination with other required services; and 24-hour emergency response.

(1) Service authorization shall be required for Medicaid reimbursement prior to the onset of services. Services rendered before the date of authorization shall not be reimbursed.

(2) Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement. Requirements for service-specific provider intakes and ISPs are set out in this section.

(3) These services may only be rendered by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, or a QMHP-E.

c. Therapeutic day treatment (TDT) shall be provided two or more hours per day in order to provide therapeutic interventions. Day treatment programs provide evaluation; medication education and management; opportunities to learn and use daily living skills and to enhance social and interpersonal skills (e.g., problem solving, anger management, community responsibility, increased impulse control, and appropriate peer relations, etc.); and individual, group and family counseling.

(1) Service authorization shall be required for Medicaid reimbursement.

(2) Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement. Requirements for service-specific provider intakes and ISPs are set out in this section.

(3) These services may be rendered only by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, or a QMHP-E.

d. Community-based services for children and adolescents younger than 21 years of age (Level A) pursuant to 42 CFR 440.031(d).

(1) Such services shall be a combination of therapeutic services rendered in a residential setting. The residential services will provide structure for daily activities, psychoeducation, therapeutic supervision, care coordination, and psychiatric treatment to ensure the attainment of therapeutic mental health goals as identified in the individual service plan (plan of care). Individuals qualifying for this service must demonstrate medical necessity for the service arising from a condition due to mental, behavioral or emotional illness that results

in significant functional impairments in major life activities in the home, school, at work, or in the community. The service must reasonably be expected to improve the child's condition or prevent regression so that the services will no longer be needed. The application of a national standardized set of medical necessity criteria in use in the industry, such as McKesson InterQual® Criteria or an equivalent standard authorized in advance by DMAS, shall be required for this service.

(2) In addition to the residential services, the child must receive, at least weekly, individual psychotherapy that is provided by an LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP.

(3) Individuals shall be discharged from this service when other less intensive services may achieve stabilization.

(4) Authorization shall be required for Medicaid reimbursement. Services that were rendered before the date of service authorization shall not be reimbursed.

(5) Room and board costs shall not be reimbursed. DMAS shall reimburse only for services provided in facilities or programs with no more than 16 beds.

(6) These residential providers must be licensed by the Department of Social Services, Department of Juvenile Justice, or Department of Behavioral Health and Developmental Services under the Standards for Licensed Children's Residential Facilities (22VAC40-151), Regulation Governing Juvenile Group Homes and Halfway Houses (6VAC35-41), or Regulations for Children's Residential Facilities (12VAC35-46).

(7) Daily progress notes shall document a minimum of seven psychoeducational activities per week. Psychoeducational programming must include development or maintenance of daily living skills, anger management, social skills, family living skills, communication skills, stress management, and any care coordination activities.

(8) The facility/group home must coordinate services with other providers. Such care coordination shall be documented in the individual's medical record. The documentation shall include who was contacted, when the contact occurred, and what information was transmitted.

(9) Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement. Requirements for intakes and ISPs are set out in 12VAC30-60-61.

(10) These services may only be rendered by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, a QMHP-E, or a QPPMH.

e. Therapeutic behavioral services (Level B) pursuant to 42 CFR 440.130(d).

(1) Such services must be therapeutic services rendered in a residential setting. The residential services will provide structure for daily activities, psychoeducation, therapeutic supervision, care coordination, and psychiatric treatment to ensure the attainment of therapeutic mental health goals as identified in the individual service plan (plan of care). Individuals qualifying for this service must demonstrate medical necessity for the service arising from a condition due to mental, behavioral or emotional illness that results in significant functional impairments in major life activities in the home, school, at work, or in the community. The service must reasonably be expected to improve the child's condition or prevent regression so that the services will no longer be needed. The application of a national standardized set of medical necessity criteria in use in the industry, such as McKesson InterQual® Criteria, or an equivalent standard authorized in advance by DMAS shall be required for this service.

(2) Authorization is required for Medicaid reimbursement. Services that are rendered before the date of service authorization shall not be reimbursed.

(3) Room and board costs shall not be reimbursed. Facilities that only provide independent living services are not reimbursed. DMAS shall reimburse only for services provided in facilities or programs with no more than 16 beds.

(4) These residential providers must be licensed by the Department of Behavioral Health and Developmental Services (DBHDS) under the Regulations for Children's Residential Facilities (12VAC35-46).

(5) Daily progress notes shall document that a minimum of seven psychoeducational activities per week occurs. Psychoeducational programming must include development or maintenance of daily living skills, anger management, social skills, family living skills, communication skills, and stress management. This service may be provided in a program setting or a community-based group home.

(6) The individual must receive, at least weekly, individual psychotherapy and, at least weekly, group psychotherapy that is provided as part of the program.

(7) Individuals shall be discharged from this service when other less intensive services may achieve stabilization.

(8) Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services that are based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement. Requirements for intakes and ISPs are set out in 12VAC30-60-61.

(9) These services may only be rendered by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, a QMHP-E, or a QPPMH.

(10) The facility/group home shall coordinate necessary services with other providers. Documentation of this care coordination shall be maintained by the facility/group home in the individual's record. The documentation shall include who was contacted, when the contact occurred, and what information was transmitted.

f. Mental health family support partners.

(1) Mental health family support partners are peer recovery support services and are nonclinical, peer-to-peer activities that engage, educate, and support the caregiver and an individual's self-help efforts to improve health recovery resiliency and wellness. Mental health family support partners is a peer support service and is a strength-based, individualized service provided to the caregiver of a Medicaid-eligible individual younger than 21 years of age with a mental health disorder that is the focus of support. The services provided to the caregiver and individual must be directed exclusively toward the benefit of the Medicaid-eligible individual. Services are expected to improve outcomes for individuals younger than 21 years of age with complex needs who are involved with multiple systems and increase the individual's and family's confidence and capacity to manage their own services and supports while promoting recovery and healthy relationships. These services are rendered by a PRS who is (i) a parent of a minor or adult child with a similar mental health disorder or (ii) an adult with personal experience with a family member with a similar mental health disorder with experience navigating behavioral health care services. The PRS shall perform the service within the scope of his knowledge, lived experience, and education.

(2) Under the clinical oversight of the LMHP making the recommendation for mental health family support partners, the peer recovery specialist in consultation with his direct supervisor shall develop a recovery, resiliency, and wellness plan based on the LMHP's recommendation for service, the individual's and the caregiver's perceived recovery needs, and any clinical assessments or service specific provider intakes as defined in this section within 30 calendar days of the initiation of service. Development of the recovery, resiliency, and wellness plan shall include collaboration with the individual and the individual's caregiver. Individualized goals and strategies shall be focused on the individual's identified needs for self-advocacy and recovery. The recovery, resiliency, and wellness plan shall also include documentation of how many days per week and how many hours per week are required to carry out the services in order to meet the goals of the plan. The recovery, resiliency, and wellness plan shall be completed, signed, and dated by the LMHP, the PRS, the direct supervisor, the individual, and the individual's caregiver within 30 calendar days of the initiation of service. The PRS shall act as an advocate for the individual, encouraging the individual and the caregiver to take a proactive role in developing and updating goals and objectives in the individualized recovery planning.

(3) Documentation of required activities shall be required as set forth in 12VAC30-130-5200 A ~~and~~, C, and E through J.

(4) Limitations and exclusions to service delivery shall be the same as set forth in 12VAC30-130-5210.

(5) Caregivers of individuals younger than 21 years of age who qualify to receive mental health family support partners (i) care for an individual with a mental health disorder who requires recovery assistance and (ii) meet two or more of the following:

(a) Individual and his caregiver need peer-based recovery-oriented services for the maintenance of wellness and the acquisition of skills needed to support the individual.

(b) Individual and his caregiver need assistance to develop self-advocacy skills to assist the individual in achieving self-management of the individual's health status.

(c) Individual and his caregiver need assistance and support to prepare the individual for a successful work or school experience.

(d) Individual and his caregiver need assistance to help the individual and caregiver assume responsibility for recovery.

(6) Individuals 18 through 20 years of age who meet the medical necessity criteria in 12VAC30-50-226 B 7 e, who would benefit from receiving peer supports directly and who choose to receive mental health peer support services directly instead of through their caregiver, shall be permitted to receive mental health peer support services by an appropriate PRS.

(7) To qualify for continued mental health family support partners, ~~the requirements for continued services set forth in 12VAC30-130-5180 D shall be met~~ medical necessity criteria shall continue to be met, and progress notes shall

document the status of progress relative to the goals identified in the recovery, resiliency, and wellness plan.

(8) Discharge criteria from mental health family support partners shall be the same as set forth in 12VAC30-130-5180 E.

(9) Mental health family support partners services shall be rendered on an individual basis or in a group.

(10) Prior to service initiation, a documented recommendation for mental health family support partners services shall be made by a licensed mental health professional (LMHP) who is acting within his scope of practice under state law. The recommendation shall verify that the individual meets the medical necessity criteria set forth in subdivision 5 of this subsection. The recommendation shall be valid for no longer than 30 calendar days.

(11) Effective July 1, 2017, a peer recovery specialist shall have the qualifications, education, experience, and certification required by DBHDS in order to be eligible to register with the Virginia Board of Counseling on or after July 1, 2018. Upon the promulgation of regulations by the Board of Counseling, registration of peer recovery specialists by the Board of Counseling shall be required. The PRS shall perform mental health family support partners services under the oversight of the LMHP making the recommendation for services and providing the clinical oversight of the recovery, resiliency, and wellness plan.

(12) The PRS shall be employed by or have a contractual relationship with the enrolled provider licensed for one of the following:

(a) Acute care general and emergency department hospital services licensed by the Department of Health.

(b) Freestanding psychiatric hospital and inpatient psychiatric unit licensed by the Department of Behavioral Health and Developmental Services.

(c) Psychiatric residential treatment facility licensed by the Department of Behavioral Health and Developmental Services.

(d) Therapeutic group home licensed by the Department of Behavioral Health and Developmental Services.

(e) Outpatient mental health clinic services licensed by the Department of Behavioral Health and Developmental Services.

(f) Outpatient psychiatric services provider.

(g) A community mental health and rehabilitative services provider licensed by the Department of Behavioral Health and Developmental Services as a provider of one of the following community mental health and rehabilitative services as defined in this section, 12VAC30-50-226, 12VAC30-50-420, or 12VAC30-50-430 for which the individual younger than 21 years meets medical necessity criteria (i) intensive in home; (ii) therapeutic day treatment; (iii) day treatment or partial hospitalization; (iv) crisis intervention; (v) crisis stabilization; (vi) mental health skill building; or (vii) mental health case management.

(13) Only the licensed and enrolled provider as referenced in subdivision 5 f (12) of this subsection shall be eligible to bill and receive reimbursement from DMAS or its contractor for mental health family support partner services. Payments shall not be permitted to providers that fail to enter into an enrollment agreement with DMAS or its contractor. Reimbursement shall be subject to retraction for any billed service that is determined not to be in compliance with DMAS requirements.

(14) Supervision of the PRS shall ~~be required as~~ meet the requirements set forth in ~~12VAC30-130-5190 E and 12VAC30-130-5200 G~~ 12VAC30-50-226 B 7 l.

6. Inpatient psychiatric services shall be covered for individuals younger than age 21 for medically necessary stays in inpatient psychiatric facilities described in 42 CFR 440.160(b)(1) and (b)(2) for the purpose of diagnosis and treatment of mental health and behavioral disorders identified under EPSDT when such services are rendered by (i) a psychiatric hospital or an inpatient psychiatric program in a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations; or (ii) a psychiatric facility that is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Commission on Accreditation of Rehabilitation Facilities. Inpatient psychiatric hospital admissions at general acute care hospitals and freestanding psychiatric hospitals shall also be subject to the requirements of 12VAC30-50-100, 12VAC30-50-105, and 12VAC30-60-25. Inpatient psychiatric admissions to residential treatment facilities shall also be subject to the requirements of Part XIV (12VAC30-130-850 et seq.) of Amount, Duration and Scope of Selected Services.

a. The inpatient psychiatric services benefit for individuals younger than 21 years of age shall include services defined at 42 CFR 440.160 that are provided under the direction of a physician pursuant to a certification of medical necessity and plan of care developed by an interdisciplinary team of professionals and shall involve active treatment designed to achieve the child's discharge from inpatient status at the earliest possible time. The inpatient psychiatric services benefit shall include services provided under arrangement furnished by Medicaid enrolled providers other than the inpatient psychiatric facility, as long as the inpatient

psychiatric facility (i) arranges for and oversees the provision of all services, (ii) maintains all medical records of care furnished to the individual, and (iii) ensures that the services are furnished under the direction of a physician. Services provided under arrangement shall be documented by a written referral from the inpatient psychiatric facility. For purposes of pharmacy services, a prescription ordered by an employee or contractor of the facility who is licensed to prescribe drugs shall be considered the referral.

b. Eligible services provided under arrangement with the inpatient psychiatric facility shall vary by provider type as described in this subsection. For purposes of this section, emergency services means the same as is set out in 12VAC30-50-310 B.

(1) State freestanding psychiatric hospitals shall arrange for, maintain records of, and ensure that physicians order these services: (i) pharmacy services and (ii) emergency services.

(2) Private freestanding psychiatric hospitals shall arrange for, maintain records of, and ensure that physicians order these services: (i) medical and psychological services including those furnished by physicians, licensed mental health professionals, and other licensed or certified health professionals (i.e., nutritionists, podiatrists, respiratory therapists, and substance abuse treatment practitioners); (ii) outpatient hospital services; (iii) physical therapy, occupational therapy, and therapy for individuals with speech, hearing, or language disorders; (iv) laboratory and radiology services; (v) vision services; (vi) dental, oral surgery, and orthodontic services; (vii) transportation services; and (viii) emergency services.

(3) Residential treatment facilities, as defined at 42 CFR 483.352, shall arrange for, maintain records of, and ensure that physicians order these services: (i) medical and psychological services, including those furnished by physicians, licensed mental health professionals, and other licensed or certified health professionals (i.e., nutritionists, podiatrists, respiratory therapists, and substance abuse treatment practitioners); (ii) pharmacy services; (iii) outpatient hospital services; (iv) physical therapy, occupational therapy, and therapy for individuals with speech, hearing, or language disorders; (v) laboratory and radiology services; (vi) durable medical equipment; (vii) vision services; (viii) dental, oral surgery, and orthodontic services; (ix) transportation services; and (x) emergency services.

c. Inpatient psychiatric services are reimbursable only when the treatment program is fully in compliance with (i) 42 CFR Part 441 Subpart D, specifically 42 CFR 441.151(a) and (b) and 42 CFR 441.152 through 42 CFR 441.156, and (ii) the conditions of participation in 42 CFR Part 483 Subpart G. Each admission must be preauthorized and the treatment must meet DMAS requirements for clinical necessity.

d. Service limits may be exceeded based on medical necessity for individuals eligible for EPSDT.

7. Hearing aids shall be reimbursed for individuals younger than 21 years of age according to medical necessity when provided by practitioners licensed to engage in the practice of fitting or dealing in hearing aids under the Code of Virginia.

8. Addiction and recovery treatment services shall be covered under EPSDT consistent with 12VAC30-130-5000 et seq.

9. Services facilitators shall be required for all consumer-directed personal care services consistent with the requirements set out in 12VAC30-120-935.

10. Behavioral therapy services shall be covered for individuals younger than 21 years of age.

a. Definitions. The following words and terms when used in this subsection shall have the following meanings unless the context clearly indicates otherwise:

"Behavioral therapy" means systematic interventions provided by licensed practitioners acting within the scope of practice defined under a Virginia Department of Health Professions regulatory board and covered as remedial care under 42 CFR 440.130(d) to individuals younger than 21 years of age. Behavioral therapy includes applied behavioral analysis. Family training related to the implementation of the behavioral therapy shall be included as part of the behavioral therapy service. Behavioral therapy services shall be subject to clinical reviews and determined as medically necessary. Behavioral therapy may be provided in the individual's home and community settings as deemed by DMAS or its contractor as medically necessary treatment.

"Counseling" means a professional mental health service that can only be provided by a person holding a license issued by a health regulatory board at the Department of Health Professions, which includes conducting assessments, making diagnoses of mental disorders and conditions, establishing treatment plans, and determining treatment interventions.

"Individual" means the child or adolescent younger than 21 years of age who is receiving behavioral therapy services.

"Primary care provider" means a licensed medical practitioner who provides preventive and primary health care and is responsible for providing routine EPSDT screening and referral and coordination of other medical services needed by the individual.

b. Behavioral therapy services shall be designed to enhance communication skills and decrease maladaptive patterns of behavior, which if left untreated, could lead to more complex problems and the need for a greater or a more intensive level of care. The service goal shall be to ensure the individual's family or caregiver is trained to effectively manage the individual's behavior in the home using modification strategies. All services shall be provided in accordance with the ISP and clinical assessment summary.

c. Behavioral therapy services shall be covered when recommended by the individual's primary care provider or other licensed physician, licensed physician assistant, or licensed nurse practitioner and determined by DMAS or its contractor to be medically necessary to correct or ameliorate significant impairments in major life activities that have resulted from either developmental, behavioral, or mental disabilities. Criteria for medical necessity are set out in 12VAC30-60-61 H. Service-specific provider intakes shall be required at the onset of these services in order to receive authorization for reimbursement. Individual service plans (ISPs) shall be required throughout the entire duration of services. The services shall be provided in accordance with the individual service plan and clinical assessment summary. These services shall be provided in settings that are natural or normal for a child or adolescent without a disability, such as the individual's home, unless there is justification in the ISP, which has been authorized for reimbursement, to include service settings that promote a generalization of behaviors across different settings to maintain the targeted functioning outside of the treatment setting in the individual's home and the larger community within which the individual resides. Covered behavioral therapy services shall include:

(1) Initial and periodic service-specific provider intake as defined in 12VAC30-60-61 H;

(2) Development of initial and updated ISPs as established in 12VAC30-60-61 H;

(3) Clinical supervision activities. Requirements for clinical supervision are set out in 12VAC30-60-61 H;

(4) Behavioral training to increase the individual's adaptive functioning and communication skills;

(5) Training a family member in behavioral modification methods as established in 12VAC30-60-61 H;

(6) Documentation and analysis of quantifiable behavioral data related to the treatment objectives; and

(7) Care coordination.

C. School health services.

1. School health assistant services are repealed effective July 1, 2006.

2. School divisions may provide routine well-child screening services under the State Plan. Diagnostic and treatment services that are otherwise covered under early and periodic screening, diagnosis and treatment services, shall not be covered for school divisions. School divisions to receive reimbursement for the screenings shall be enrolled with DMAS as clinic providers.

a. Children enrolled in managed care organizations shall receive screenings from those organizations. School divisions shall not receive reimbursement for screenings from DMAS for these children.

b. School-based services are listed in a recipient's individualized education program (IEP) and covered under one or more of the service categories described in § 1905(a) of the Social Security Act. These services are necessary to correct or ameliorate defects of physical or mental illnesses or conditions.

3. Providers shall be licensed under the applicable state practice act or comparable licensing criteria by the Virginia Department of Education, and shall meet applicable qualifications under 42 CFR Part 440. Identification of defects, illnesses or conditions and services necessary to correct or ameliorate them shall be performed by practitioners qualified to make those determinations within their licensed scope of practice, either as a member of the IEP team or by a qualified practitioner outside the IEP team.

a. Providers shall be employed by the school division or under contract to the school division.

b. Supervision of services by providers recognized in subdivision 4 of this subsection shall occur as allowed under federal regulations and consistent with Virginia law, regulations, and DMAS provider manuals.

c. The services described in subdivision 4 of this subsection shall be delivered by school providers, but may also be available in the community from other providers.

d. Services in this subsection are subject to utilization control as provided under 42 CFR Parts 455 and 456.

e. The IEP shall determine whether or not the services described in subdivision 4 of this subsection are medically necessary and that the treatment prescribed is in accordance with standards of medical practice. Medical necessity is defined as services ordered by IEP providers. The IEP providers are qualified Medicaid providers to make the medical necessity determination in

accordance with their scope of practice. The services must be described as to the amount, duration and scope.

4. Covered services include:

a. Physical therapy, occupational therapy and services for individuals with speech, hearing, and language disorders, performed by, or under the direction of, providers who meet the qualifications set forth at 42 CFR 440.110. This coverage includes audiology services.

b. Skilled nursing services are covered under 42 CFR 440.60. These services are to be rendered in accordance to the licensing standards and criteria of the Virginia Board of Nursing. Nursing services are to be provided by licensed registered nurses or licensed practical nurses but may be delegated by licensed registered nurses in accordance with the regulations of the Virginia Board of Nursing, especially the section on delegation of nursing tasks and procedures. The licensed practical nurse is under the supervision of a registered nurse.

(1) The coverage of skilled nursing services shall be of a level of complexity and sophistication (based on assessment, planning, implementation and evaluation) that is consistent with skilled nursing services when performed by a licensed registered nurse or a licensed practical nurse. These skilled nursing services shall include dressing changes, maintaining patent airways, medication administration/monitoring and urinary catheterizations.

(2) Skilled nursing services shall be directly and specifically related to an active, written plan of care developed by a registered nurse that is based on a written order from a physician, physician assistant or nurse practitioner for skilled nursing services. This order shall be recertified on an annual basis.

c. Psychiatric and psychological services performed by licensed practitioners within the scope of practice are defined under state law or regulations and covered as physicians' services under 42 CFR 440.50 or medical or other remedial care under 42 CFR 440.60. These outpatient services include individual medical psychotherapy, group medical psychotherapy coverage, and family medical psychotherapy. Psychological and neuropsychological testing are allowed when done for purposes other than educational diagnosis, school admission, evaluation of an individual with intellectual disability prior to admission to a nursing facility, or any placement issue. These services are covered in the nonschool settings also. School providers who may render these services when licensed by the state include psychiatrists, licensed clinical psychologists, school psychologists, licensed clinical social workers, professional counselors, psychiatric clinical nurse specialists, marriage and family therapists, and school social workers.

d. Personal care services are covered under 42 CFR 440.167 and performed by persons qualified under this subsection. The personal care assistant is supervised by a DMAS recognized school-based health professional who is acting within the scope of licensure. This practitioner develops a written plan for meeting the needs of the child, which is implemented by the assistant. The assistant must have qualifications comparable to those for other personal care aides recognized by the Virginia Department of Medical Assistance Services. The assistant performs services such as assisting with toileting, ambulation, and eating. The assistant may serve as an aide on a specially adapted school vehicle that enables transportation to or from the school or school contracted provider on days when the student is receiving a Medicaid-covered service under the IEP. Children requiring an aide during transportation on a specially adapted vehicle shall have this stated in the IEP.

e. Medical evaluation services are covered as physicians' services under 42 CFR 440.50 or as medical or other remedial care under 42 CFR 440.60. Persons performing these services shall be licensed physicians, physician assistants, or nurse practitioners. These practitioners shall identify the nature or extent of a child's medical or other health related condition.

f. Transportation is covered as allowed under 42 CFR 431.53 and described at State Plan Attachment 3.1-D (12VAC30-50-530). Transportation shall be rendered only by school division personnel or contractors. Transportation is covered for a child who requires transportation on a specially adapted school vehicle that enables transportation to or from the school or school contracted provider on days when the student is receiving a Medicaid-covered service under the IEP. Transportation shall be listed in the child's IEP. Children requiring an aide during transportation on a specially adapted vehicle shall have this stated in the IEP.

g. Assessments are covered as necessary to assess or reassess the need for medical services in a child's IEP and shall be performed by any of the above licensed practitioners within the scope of practice. Assessments and reassessments not tied to medical needs of the child shall not be covered.

5. DMAS will ensure through quality management review that duplication of services will be monitored. School divisions have a responsibility to ensure that if a child is receiving additional therapy outside of the school, that there will be coordination of services to avoid duplication of service.

D. Family planning services and supplies for individuals of child-bearing age.

1. Service must be ordered or prescribed and directed or performed within the scope of the license of a practitioner of the healing arts.

2. Family planning services shall be defined as those services that delay or prevent pregnancy. Coverage of such services shall not include services to treat infertility or services to promote fertility. Family planning services shall not cover payment for abortion services and no funds shall be used to perform, assist, encourage, or make direct referrals for abortions.

3. Family planning services as established by § 1905(a)(4)(C) of the Social Security Act include annual family planning exams; cervical cancer screening for women; sexually transmitted infection (STI) testing; lab services for family planning and STI testing; family planning education, counseling, and preconception health; sterilization procedures; nonemergency transportation to a family planning service; and U.S. Food and Drug Administration approved prescription and over-the-counter contraceptives, subject to limits in 12VAC30-50-210.

12VAC30-50-226. Community mental health services.

A. Definitions. The following words and terms when used in this section shall have the following meanings unless the context clearly indicates otherwise:

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

"Affiliated" means any entity or property in which a provider or facility has a direct or indirect ownership interest of 5.0% or more, or any management, partnership, or control of an entity.

"Behavioral health service" means the same as defined in 12VAC30-130-5160.

"Behavioral health services administrator" or "BHSA" means an entity that manages or directs a behavioral health benefits program under contract with DMAS. DMAS' designated BHSA shall be authorized to constitute, oversee, enroll, and train a provider network; perform service authorization; adjudicate claims; process claims; gather and maintain data; reimburse providers; perform quality assessment and improvement; conduct member outreach and education; resolve member and provider issues; and perform utilization management including care coordination for the provision of Medicaid-covered behavioral health services. Such authority shall include entering into or terminating contracts with providers in accordance with DMAS authority pursuant to 42 CFR Part 1002 and § 32.1-325 D and E of the Code of Virginia. DMAS shall retain authority for and oversight of the BHSA entity or entities.

"Certified prescreener" means an employee of either the local community services board/behavioral health authority or its designee who is skilled in the assessment and treatment of mental illness and who has completed a certification program approved by DBHDS.

"Clinical experience" means, for the purpose of rendering (i) mental health day treatment/partial hospitalization, (ii) intensive community treatment, (iii) psychosocial rehabilitation, (iv) mental health skill building, (v) crisis stabilization, or (vi) crisis intervention services, practical experience in providing direct services to individuals with diagnoses of mental illness or intellectual disability or the provision of direct geriatric services or special education services. Experience shall include supervised internships, supervised practicums, or supervised field experience. Experience shall not include unsupervised internships, unsupervised practicums, and unsupervised field experience. The equivalency of part-time hours to full-time hours for the purpose of this requirement shall be established by DBHDS in the document titled Human Services and Related Fields Approved Degrees/Experience, issued March 12, 2013, revised May 3, 2013.

"Code" means the Code of Virginia.

"DBHDS" means the Department of Behavioral Health and Developmental Services consistent with Chapter 3 (§ 37.2-300 et seq.) of Title 37.2 of the Code of Virginia.

"Direct supervisor" means the person who provides direct supervision to the peer recovery specialist. The direct supervisor (i) shall have two consecutive years of documented practical experience rendering peer support services or family support services, have certification training as a PRS under a certifying body approved by DBHDS, and have documented completion of the DBHDS PRS supervisor training; (ii) shall be a qualified mental health professional (QMHP-A, QMHP-C, or QMHP-E) as defined in 12VAC35-105-20 with at least two consecutive years of documented experience as a QMHP, and who has documented completion of the DBHDS PRS supervisor training; or (iii) shall be an LMHP who has documented completion of the DBHDS PRS supervisor training who is acting within his scope of practice under state law. An LMHP providing services before April 1, 2018, shall have until April 1, 2018, to complete the DBHDS PRS supervisor training.

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

"DSM-5" means the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, copyright 2013, American Psychiatric Association.

"Human services field" means the same as the term is defined by DBHDS in the guidance document entitled Human Services and Related Fields Approved Degrees/Experience, issued March 12, 2013, revised May 3, 2013.

"Individual" means the patient, client, or recipient of services described in this section.

"Individual service plan" or "ISP" means a comprehensive and regularly updated treatment plan specific to the individual's unique treatment needs as identified in the service-specific provider intake. The ISP contains, but is not limited to, the individual's treatment or training needs, the individual's goals and measurable objectives to meet the identified needs, services to be provided with the recommended frequency to accomplish the measurable goals and objectives, the estimated timetable for achieving the goals and objectives, and an individualized discharge plan that describes transition to other appropriate services. The individual shall be included in the development of the ISP and the ISP shall be signed by the individual. If the individual is a minor child, the ISP shall also be signed by the individual's parent/legal guardian. Documentation shall be provided if the individual, who is a minor child or an adult who lacks legal capacity, is unable or unwilling to sign the ISP.

"Individualized training" means instruction and practice in functional skills and appropriate behavior related to the individual's health and safety, instrumental activities of daily living skills, and use of community resources; assistance with medical management; and monitoring health, nutrition, and physical condition. The training shall be rehabilitative and based on a variety of incremental (or cumulative) approaches or tools to organize and guide the individual's life planning and shall reflect what is important to the individual in addition to all other factors that affect his functioning, including effects of the disability and issues of health and safety.

"Licensed mental health professional" or "LMHP" means the same as defined in 12VAC35-105-20.

"LMHP-resident" or "LMHP-R" means the same as "resident" as defined in (i) 18VAC115-20-10 for licensed professional counselors; (ii) 18VAC115-50-10 for licensed marriage and family therapists; or (iii) 18VAC115-60-10 for licensed substance abuse treatment practitioners. An LMHP-resident shall be in continuous compliance with the regulatory requirements of the applicable counseling profession for supervised practice and shall not perform the functions of the LMHP-R or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Counseling. For purposes of Medicaid reimbursement to their supervisors for services provided by such residents, they shall use the title "Resident" in connection with the applicable profession after their signatures to indicate such status.

"LMHP-resident in psychology" or "LMHP-RP" means the same as an individual in a residency, as that term is defined in 18VAC125-20-10, program for clinical psychologists. An LMHP-resident in psychology shall be in continuous compliance with the regulatory requirements for supervised experience as found in 18VAC125-20-65 and shall not perform the functions of the LMHP-RP or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Psychology. For purposes of Medicaid reimbursement by supervisors for services provided by such residents, they shall use the title "Resident in Psychology" after their signatures to indicate such status.

"LMHP-supervisee in social work," "LMHP-supervisee," or "LMHP-S" means the same as "supervisee" is defined in 18VAC140-20-10 for licensed clinical social workers. An LMHP-supervisee in social work shall be in continuous compliance with the regulatory requirements for supervised practice as found in 18VAC140-20-50 and shall not perform the functions of the LMHP-S or be considered a "supervisee" until the supervision for specific clinical duties at a specific site is preapproved in writing by the Virginia Board of Social Work. For purposes of Medicaid reimbursement to their supervisors for services provided by supervisees, these persons shall use the title "Supervisee in Social Work" after their signatures to indicate such status.

"Peer recovery specialist" or "PRS" means the same as defined in 12VAC30-130-5160.

"Person centered" means the same as defined in 12VAC30-130-5160.

"Qualified mental health professional-adult" or "QMHP-A" means the same as defined in 12VAC35-105-20.

"Qualified mental health professional-child" or "QMHP-C" means the same as defined in 12VAC35-105-20.

"Qualified mental health professional-eligible" or "QMHP-E" means the same as defined in 12VAC35-105-20.

"Qualified paraprofessional in mental health" or "QPPMH" means the same as defined in 12VAC35-105-20.

"Recovery-oriented services" means the same as defined in 12VAC30-130-5160.

"Recovery, resiliency, and wellness plan" means the same as defined in 12VAC30-130-5160.

"Register" or "registration" means notifying DMAS or its contractor that an individual will be receiving services that do not require service authorization.

"Resiliency" means the same as defined in 12VAC30-130-5160.

"Review of ISP" means that the provider evaluates and updates the individual's progress toward meeting the

individualized service plan objectives and documents the outcome of this review. For DMAS to determine that these reviews are satisfactory and complete, the reviews shall (i) update the goals, objectives, and strategies of the ISP to reflect any change in the individual's progress and treatment needs as well as any newly identified problems; (ii) be conducted in a manner that enables the individual to participate in the process; and (iii) be documented in the individual's medical record no later than 15 calendar days from the date of the review.

"Self-advocacy" means the same as defined in 12VAC30-130-5160.

"Service authorization" means the process to approve specific services for an enrolled Medicaid, FAMIS Plus, or FAMIS individual by a DMAS service authorization contractor prior to service delivery and reimbursement in order to validate that the service requested is medically necessary and meets DMAS and DMAS contractor criteria for reimbursement. Service authorization does not guarantee payment for the service.

"Service-specific provider intake" means the same as defined in 12VAC30-50-130 and also includes individuals who are older than 21 years of age.

"Strength-based" means the same as defined in 12VAC30-130-5160.

"Supervision" means the same as defined in 12VAC30-130-5160.

B. Mental health services. The following services, with their definitions, shall be covered: day treatment/partial hospitalization, psychosocial rehabilitation, crisis services, intensive community treatment (ICT), and mental health skill building. Staff travel time shall not be included in billable time for reimbursement. These services, in order to be covered, shall meet medical necessity criteria based upon diagnoses made by LMHPs who are practicing within the scope of their licenses and are reflected in provider records and on providers' claims for services by recognized diagnosis codes that support and are consistent with the requested professional services. These services are intended to be delivered in a person-centered manner. The individuals who are receiving these services shall be included in all service planning activities. All services which do not require service authorization require registration. This registration shall transmit service-specific information to DMAS or its contractor in accordance with service authorization requirements.

1. Day treatment/partial hospitalization services shall be provided in sessions of two or more consecutive hours per day, which may be scheduled multiple times per week, to groups of individuals in a nonresidential setting. These services, limited annually to 780 units, include the major diagnostic, medical, psychiatric, psychosocial, and psychoeducational treatment modalities designed for individuals who require coordinated, intensive, comprehensive, and multidisciplinary treatment but who do not require inpatient treatment. One unit of service shall be defined as a minimum of two but less than four hours on a given day. Two units of service shall be defined as at least four but less than seven hours in a given day. Three units of service shall be defined as seven or more hours in a given day. Authorization is required for Medicaid reimbursement.

a. Day treatment/partial hospitalization services shall be time limited interventions that are more intensive than outpatient services and are required to stabilize an individual's psychiatric condition. The services are delivered when the individual is at risk of psychiatric hospitalization or is transitioning from a psychiatric hospitalization to the community. The service-specific provider intake, as defined at 12VAC30-50-130, shall document the individual's behavior and describe how the individual is at risk of psychiatric hospitalization or is transitioning from a psychiatric hospitalization to the community.

b. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from mental, behavioral, or emotional illness that results in significant functional impairments in major life activities. Individuals must meet at least two of the following criteria on a continuing or intermittent basis:

(1) Experience difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or homelessness or isolation from social supports;

(2) Experience difficulty in activities of daily living such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized;

(3) Exhibit such inappropriate behavior that the individual requires repeated interventions or monitoring by the mental health, social services, or judicial system that have been documented; or

(4) Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or recognize significantly inappropriate social behavior.

c. Individuals shall be discharged from this service when they are no longer in an acute psychiatric state and other less intensive services may achieve psychiatric stabilization.

d. Admission and services for time periods longer than 90 calendar days must be authorized based upon a face-to-face evaluation by a physician, psychiatrist, licensed clinical psychologist, licensed professional counselor,

licensed clinical social worker, or psychiatric clinical nurse specialist.

e. These services may only be rendered by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, QMHP-A, QMHP-C, QMHP-E, or a QPPMH.

2. Psychosocial rehabilitation shall be provided at least two or more hours per day to groups of individuals in a nonresidential setting. These services, limited annually to 936 units, include assessment, education to teach the patient about the diagnosed mental illness and appropriate medications to avoid complication and relapse, opportunities to learn and use independent living skills and to enhance social and interpersonal skills within a supportive and normalizing program structure and environment. One unit of service is defined as a minimum of two but less than four hours on a given day. Two units are defined as at least four but less than seven hours in a given day. Three units of service shall be defined as seven or more hours in a given day. Authorization is required for Medicaid reimbursement. The service-specific provider intake, as defined at 12VAC30-50-130, shall document the individual's behavior and describe how the individual meets criteria for this service.

a. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from mental, behavioral, or emotional illness that results in significant functional impairments in major life activities. Services are provided to individuals: (i) who without these services would be unable to remain in the community or (ii) who meet at least two of the following criteria on a continuing or intermittent basis:

(1) Experience difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of psychiatric hospitalization, homelessness, or isolation from social supports;

(2) Experience difficulty in activities of daily living such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized;

(3) Exhibit such inappropriate behavior that repeated interventions documented by the mental health, social services, or judicial system are or have been necessary; or

(4) Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or significantly inappropriate social behavior.

b. These services may only be rendered by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, QMHP-A, QMHP-C, QMHP-E, or a QPPMH.

3. Crisis intervention shall provide immediate mental health care, available 24 hours a day, seven days per week, to assist individuals who are experiencing acute psychiatric dysfunction requiring immediate clinical attention. This service's objectives shall be to prevent exacerbation of a condition, to prevent injury to the client or others, and to provide treatment in the context of the least restrictive setting. Crisis intervention activities shall include assessing the crisis situation, providing short-term counseling designed to stabilize the individual, providing access to further immediate assessment and follow-up, and linking the individual and family with ongoing care to prevent future crises. Crisis intervention services may include office visits, home visits, preadmission screenings, telephone contacts, and other client-related activities for the prevention of institutionalization. The service-specific provider intake, as defined at 12VAC30-50-130, shall document the individual's behavior and describe how the individual meets criteria for this service. The provision of this service to an individual shall be registered with either DMAS, DMAS contractors, or the BHSA within one business day or the completion of the service-specific provider intake to avoid duplication of services and to ensure informed care coordination.

a. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from an acute crisis of a psychiatric nature that puts the individual at risk of psychiatric hospitalization. Individuals must meet at least two of the following criteria at the time of admission to the service:

(1) Experience difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of psychiatric hospitalization, homelessness, or isolation from social supports;

(2) Experience difficulty in activities of daily living such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized;

(3) Exhibit such inappropriate behavior that immediate interventions documented by mental health, social services, or the judicial system are or have been necessary; or

(4) Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or significantly inappropriate social behavior.

b. The annual limit for crisis intervention is 720 units per year. A unit shall equal 15 minutes.

c. These services may only be rendered by an LMHP, an LMHP-supervisee, LMHP-resident, LMHP-RP, or a certified prescreener.

4. Intensive community treatment (ICT), initially covered for a maximum of 26 weeks based on an initial service-specific provider intake and may be reauthorized for up to

an additional 26 weeks annually based on written intake and certification of need by a licensed mental health provider (LMHP), shall be defined by 12VAC35-105-20 or LMHP-S, LMHP-R, and LMHP-RP and shall include medical psychotherapy, psychiatric assessment, medication management, and care coordination activities offered to outpatients outside the clinic, hospital, or office setting for individuals who are best served in the community. Authorization is required for Medicaid reimbursement.

a. To qualify for ICT, the individual must meet at least one of the following criteria:

(1) The individual must be at high risk for psychiatric hospitalization or becoming or remaining homeless due to mental illness or require intervention by the mental health or criminal justice system due to inappropriate social behavior.

(2) The individual has a history (three months or more) of a need for intensive mental health treatment or treatment for co-occurring serious mental illness and substance use disorder and demonstrates a resistance to seek out and utilize appropriate treatment options.

b. A written, service-specific provider intake, as defined at 12VAC30-50-130, that documents the individual's eligibility and the need for this service must be completed prior to the initiation of services. This intake must be maintained in the individual's records.

c. An individual service plan shall be initiated at the time of admission and must be fully developed, as defined in this section, within 30 days of the initiation of services.

d. The annual unit limit shall be 130 units with a unit equaling one hour.

e. These services may only be rendered by a team that meets the requirements of 12VAC35-105-1370.

5. Crisis stabilization services for nonhospitalized individuals shall provide direct mental health care to individuals experiencing an acute psychiatric crisis which may jeopardize their current community living situation. Services may be provided for up to a 15-day period per crisis episode following a face-to-face service-specific provider intake by an LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP. Only one unit of service shall be reimbursed for this intake. The provision of this service to an individual shall be registered with either DMAS, DMAS contractors, or the BHSA within one business day of the completion of the service-specific provider intake to avoid duplication of services and to ensure informed care coordination.

a. The goals of crisis stabilization programs shall be to avert hospitalization or rehospitalization, provide normative environments with a high assurance of safety and security for crisis intervention, stabilize individuals in psychiatric crisis, and mobilize the resources of the community support system and family members and others for on-going maintenance and rehabilitation. The services must be documented in the individual's records as having been provided consistent with the ISP in order to receive Medicaid reimbursement.

b. The crisis stabilization program shall provide to individuals, as appropriate, psychiatric assessment including medication evaluation, treatment planning, symptom and behavior management, and individual and group counseling.

c. This service may be provided in any of the following settings, but shall not be limited to: (i) the home of an individual who lives with family or other primary caregiver; (ii) the home of an individual who lives independently; or (iii) community-based programs licensed by DBHDS to provide residential services but which are not institutions for mental disease (IMDs).

d. This service shall not be reimbursed for (i) individuals with medical conditions that require hospital care; (ii) individuals with primary diagnosis of substance abuse; or (iii) individuals with psychiatric conditions that cannot be managed in the community (i.e., individuals who are of imminent danger to themselves or others).

e. The maximum limit on this service is 60 days annually.

f. Services must be documented through daily progress notes and a daily log of times spent in the delivery of services. The service-specific provider intake, as defined at 12VAC30-50-130, shall document the individual's behavior and describe how the individual meets criteria for this service. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from an acute crisis of a psychiatric nature that puts the individual at risk of psychiatric hospitalization. Individuals must meet at least two of the following criteria at the time of admission to the service:

(1) Experience difficulty in establishing and maintaining normal interpersonal relationships to such a degree that the individual is at risk of psychiatric hospitalization, homelessness, or isolation from social supports;

(2) Experience difficulty in activities of daily living such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized;

(3) Exhibit such inappropriate behavior that immediate interventions documented by the mental health, social services, or judicial system are or have been necessary; or

(4) Exhibit difficulty in cognitive ability such that the individual is unable to recognize personal danger or significantly inappropriate social behavior.

g. These services may only be rendered by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, QMHP-A, QMHP-C, QMHP-E or a certified prescreener.

6. Mental health skill-building services (MHSS) shall be defined as goal-directed training to enable individuals to achieve and maintain community stability and independence in the most appropriate, least restrictive environment. Authorization is required for Medicaid reimbursement. Services that are rendered before the date of service authorization shall not be reimbursed. These services may be authorized up to six consecutive months as long as the individual meets the coverage criteria for this service. The service-specific provider intake, as defined at 12VAC30-50-130, shall document the individual's behavior and describe how the individual meets criteria for this service. These services shall provide goal-directed training in the following areas in order to be reimbursed by Medicaid or the BHSA: (i) functional skills and appropriate behavior related to the individual's health and safety, instrumental activities of daily living, and use of community resources; (ii) assistance with medication management; and (iii) monitoring of health, nutrition, and physical condition with goals towards self-monitoring and self-regulation of all of these activities. Providers shall be reimbursed only for training activities defined in the ISP and only where services meet the service definition, eligibility, and service provision criteria and this section. A review of MHSS services by an LMHP, LMHP-R, LMHP-RP, or LMHP-S shall be repeated for all individuals who have received at least six months of MHSS to determine the continued need for this service.

a. Individuals qualifying for this service shall demonstrate a clinical necessity for the service arising from a condition due to mental, behavioral, or emotional illness that results in significant functional impairments in major life activities. Services are provided to individuals who require individualized goal-directed training in order to achieve or maintain stability and independence in the community.

b. Individuals ages 21 and older shall meet all of the following criteria in order to be eligible to receive mental health skill-building services:

(1) The individual shall have one of the following as a primary mental health diagnosis:

(a) Schizophrenia or other psychotic disorder as set out in the DSM-5;

(b) Major depressive disorder;

(c) Recurrent Bipolar I or Bipolar II; or

(d) Any other serious mental health disorder that a physician has documented specific to the identified individual within the past year and that includes all of the following: (i) is a serious mental illness; (ii) results in severe and recurrent disability; (iii) produces functional limitations in the individual's major life activities that are documented in the individual's medical record; and (iv) requires individualized training for the individual in order to achieve or maintain independent living in the community.

(2) The individual shall require individualized goal-directed training in order to acquire or maintain self-regulation of basic living skills, such as symptom management; adherence to psychiatric and physical health medication treatment plans; appropriate use of social skills and personal support systems; skills to manage personal hygiene, food preparation, and the maintenance of personal adequate nutrition; money management; and use of community resources.

(3) The individual shall have a prior history of any of the following: (i) psychiatric hospitalization; (ii) either residential or nonresidential crisis stabilization; (iii) intensive community treatment (ICT) or program of assertive community treatment (PACT) services; (iv) placement in a psychiatric residential treatment facility (RTC-Level C) as a result of decompensation related to the individual's serious mental illness; or (v) a temporary detention order (TDO) evaluation, pursuant to § 37.2-809 B of the Code of Virginia. This criterion shall be met in order to be initially admitted to services and not for subsequent authorizations of service. Discharge summaries from prior providers that clearly indicate (i) the type of treatment provided, (ii) the dates of the treatment previously provided, and (iii) the name of the treatment provider shall be sufficient to meet this requirement. Family member statements shall not suffice to meet this requirement.

(4) The individual shall have had a prescription for antipsychotic, mood stabilizing, or antidepressant medications within the 12 months prior to the service-specific provider intake date. If a physician or other practitioner who is authorized by his license to prescribe medications indicates that antipsychotic, mood stabilizing, or antidepressant medications are medically contraindicated for the individual, the provider shall obtain medical records signed by the physician or other licensed prescriber detailing the contraindication. This documentation shall be maintained in the individual's mental health skill-building services record, and the provider shall document and describe how the individual will be able to actively participate in and benefit from services without the assistance of medication. This criterion shall be met upon admission to services and shall not be required for subsequent authorizations of

service. Discharge summaries from prior providers that clearly indicate (i) the type of treatment provided, (ii) the dates of the treatment previously provided, and (iii) the name of the treatment provider shall be sufficient to meet this requirement. Family member statements shall not suffice to meet this requirement.

c. Individuals aged 18 to 21 years shall meet all of the following criteria in order to be eligible to receive mental health skill-building services:

(1) The individual shall not be living in a supervised setting as described in § 63.2-905.1 of the Code of Virginia. If the individual is transitioning into an independent living situation, MHSS shall only be authorized for up to six months prior to the date of transition.

(2) The individual shall have at least one of the following as a primary mental health diagnosis.

(a) Schizophrenia or other psychotic disorder as set out in the DSM-5;

(b) Major depressive disorder;

(c) Recurrent Bipolar-I or Bipolar II; or

(d) Any other serious mental health disorder that a physician has documented specific to the identified individual within the past year and that includes all of the following: (i) is a serious mental illness or serious emotional disturbance; (ii) results in severe and recurrent disability; (iii) produces functional limitations in the individual's major life activities that are documented in the individual's medical record; and (iv) requires individualized training for the individual in order to achieve or maintain independent living in the community.

(3) The individual shall require individualized goal-directed training in order to acquire or maintain self-regulation of basic living skills such as symptom management; adherence to psychiatric and physical health medication treatment plans; appropriate use of social skills and personal support systems; skills to manage personal hygiene, food preparation, and the maintenance of personal adequate nutrition; money management; and use of community resources.

(4) The individual shall have a prior history of any of the following: (i) psychiatric hospitalization; (ii) either residential or nonresidential crisis stabilization; (iii) intensive community treatment (ICT) or program of assertive community treatment (PACT) services; (iv) placement in a psychiatric residential treatment facility (RTC-Level C) as a result of decompensation related to the individual's serious mental illness; or (v) temporary detention order (TDO) evaluation pursuant to § 37.2-809 B of the Code of Virginia. This criterion shall be met in order to be initially admitted to services and not for subsequent authorizations of service. Discharge summaries from prior providers that clearly indicate (i) the type of treatment provided, (ii) the dates of the treatment previously provided, and (iii) the name of the treatment provider shall be sufficient to meet this requirement. Family member statements shall not suffice to meet this requirement.

(5) The individual shall have had a prescription for antipsychotic, mood stabilizing, or antidepressant medications, within the 12 months prior to the assessment date. If a physician or other practitioner who is authorized by his license to prescribe medications indicates that antipsychotic, mood stabilizing, or antidepressant medications are medically contraindicated for the individual, the provider shall obtain medical records signed by the physician or other licensed prescriber detailing the contraindication. This documentation of medication management shall be maintained in the individual's mental health skill-building services record. For individuals not prescribed antipsychotic, mood stabilizing, or antidepressant medications, the provider shall have documentation from the medication management physician describing how the individual will be able to actively participate in and benefit from services without the assistance of medication. This criterion shall be met in order to be initially admitted to services and not for subsequent authorizations of service. Discharge summaries from prior providers that clearly indicate (i) the type of treatment provided, (ii) the dates of the treatment previously provided, and (iii) the name of the treatment provider shall be sufficient to meet this requirement. Family member statements shall not suffice to meet this requirement.

(6) An independent clinical assessment, established in 12VAC30-130-3020, shall be completed for the individual.

d. Service-specific provider intakes shall be required at the onset of services and individual service plans (ISPs) shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement. Requirements for service-specific provider intakes and ISPs are set out in 12VAC30-50-130.

e. The yearly limit for mental health skill-building services is 520 units. Only direct face-to-face contacts and services to the individual shall be reimbursable. One unit is 1 to 2.99 hours per day, two units is 3 to 4.99 hours per day.

f. These services may only be rendered by an LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E, or QPPMH.

g. The provider shall clearly document details of the services provided during the entire amount of time billed.

h. The ISP shall not include activities that contradict or duplicate those in the treatment plan established by the group home or assisted living facility. The provider shall coordinate mental health skill-building services with the treatment plan established by the group home or assisted living facility and shall document all coordination activities in the medical record.

i. Limits and exclusions.

(1) Group home (Level A or B) and assisted living facility providers shall not serve as the mental health skill-building services provider for individuals residing in the provider's respective facility. Individuals residing in facilities may, however, receive MHSS from another MHSS agency not affiliated with the owner of the facility in which they reside.

(2) Mental health skill-building services shall not be reimbursed for individuals who are receiving in-home residential services or congregate residential services through the Intellectual Disability Waiver or Individual and Family Developmental Disabilities Support Waiver.

(3) Mental health skill-building services shall not be reimbursed for individuals who are also receiving services under the Department of Social Services independent living program (22VAC40-151), independent living services (22VAC40-131 and 22VAC40-151), or independent living arrangement (22VAC40-131) or any Comprehensive Services Act-funded independent living skills programs.

(4) Mental health skill-building services shall not be available to individuals who are receiving treatment foster care (12VAC30-130-900 et seq.).

(5) Mental health skill-building services shall not be available to individuals who reside in intermediate care facilities for individuals with intellectual disabilities or hospitals.

(6) Mental health skill-building services shall not be available to individuals who reside in nursing facilities, except for up to 60 days prior to discharge. If the individual has not been discharged from the nursing facility during the 60-day period of services, mental health skill-building services shall be terminated and no further service authorizations shall be available to the individual unless a provider can demonstrate and document that mental health skill-building services are necessary. Such documentation shall include facts demonstrating a change in the individual's circumstances and a new plan for discharge requiring up to 60 days of mental health skill-building services.

(7) Mental health skill-building services shall not be available for residents of residential treatment centers (Level C facilities) except for the intake code H0032 (modifier U8) in the seven days immediately prior to discharge.

(8) Mental health skill-building services shall not be reimbursed if personal care services or attendant care services are being received simultaneously, unless justification is provided why this is necessary in the individual's mental health skill-building services record. Medical record documentation shall fully substantiate the need for services when personal care or attendant care services are being provided. This applies to individuals who are receiving additional services through the Intellectual Disability Waiver (12VAC30-120-1000 et seq.), Individual and Family Developmental Disabilities Support Waiver (12VAC30-120-700 et seq.), the Elderly or Disabled with Consumer Direction Waiver (12VAC30-120-900 et seq.), and EPSDT services (12VAC30-50-130).

(9) Mental health skill-building services shall not be duplicative of other services. Providers shall be required to ensure that if an individual is receiving additional therapeutic services that there will be coordination of services by either the LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E, or QPPMH to avoid duplication of services.

(10) Individuals who have organic disorders, such as delirium, dementia, or other cognitive disorders not elsewhere classified, will be prohibited from receiving mental health skill-building services unless their physicians issue signed and dated statements indicating that the individuals can benefit from this service.

(11) Individuals who are not diagnosed with a serious mental health disorder but who have personality disorders or other mental health disorders, or both, that may lead to chronic disability shall not be excluded from the mental health skill-building services eligibility criteria provided that the individual has a primary mental health diagnosis from the list included in subdivision B 6 b (1) or B 6 c (2) of this section and that the provider can document and describe how the individual is expected to actively participate in and benefit from mental health skill-building services.

7. Mental health peer support services.

a. Mental health peer support services are peer recovery support services and are nonclinical, peer-to-peer activities that engage, educate, and support an individual's self-help efforts to improve health recovery, resiliency, and wellness. Mental health peer support

services for adults is a person centered, strength-based, and recovery-oriented rehabilitative service for individuals 21 years or older provided by a peer recovery specialist successful in the recovery process with lived experience with a mental health disorder, who is trained to offer support and assistance in helping others in the recovery to reduce the disabling effects of a mental health disorder that is the focus of support. Services assist the individual with developing and maintaining a path to recovery, resiliency, and wellness. Specific peer support service activities shall emphasize the acquisition, development, and enhancement of recovery, resiliency, and wellness. Services are designed to promote empowerment, self-determination, understanding, and coping skills through mentoring and service coordination supports, as well as to assist individuals in achieving positive coping mechanisms for the stressors and barriers encountered when recovering from their illnesses or disorders.

b. Under the clinical oversight of the LMHP making the recommendation for mental health support services, the peer recovery specialist in consultation with his direct supervisor shall develop a recovery, resiliency, and wellness plan based on the LMHP's recommendation for service, the individual's perceived recovery needs, and any clinical assessments or service specific provider intakes as defined in this section within 30 calendar days of the initiation of service. Development of the recovery, resiliency, and wellness plan shall include collaboration with the individual. Individualized goals and strategies shall be focused on the individual's identified needs for self-advocacy and recovery. The recovery, resiliency, and wellness plan shall also include documentation of how many days per week and how many hours per week are required to carry out the services in order to meet the goals of the plan. The recovery, resiliency, and wellness plan shall be completed, signed, and dated by the LMHP, the PRS, the direct supervisor, and the individual within 30 calendar days of the initiation of service. The PRS shall act as an advocate for the individual, encouraging the individual to take a proactive role in developing and updating goals and objectives in the individualized recovery planning.

c. Documentation of required activities shall be required as set forth in 12VAC30-130-5200 A ~~and~~, C, and E through J.

d. Limitations and exclusions to service delivery shall be the same as set forth in 12VAC30-130-5210.

e. Individuals 21 years or older qualifying for mental health peer support services shall meet the following requirements:

(1) Require recovery-oriented assistance and support services for the acquisition of skills needed to engage in and maintain recovery; for the development of self-advocacy skills to achieve a decreasing dependency on formalized treatment systems; and to increase responsibilities, wellness potential, and shared accountability for the individual's own recovery.

(2) Have a documented mental health disorder diagnosis.

(3) Demonstrate moderate to severe functional impairment because of a diagnosis that interferes with or limits performance in at least one of the following domains: educational (e.g., obtaining a high school or college degree); social (e.g., developing a social support system); vocational (e.g., obtaining part-time or full-time employment); self-maintenance (e.g., managing symptoms, understanding his illness, living more independently).

f. To qualify for continued mental health peer support services, ~~the requirements for continued services set forth in 12VAC30-130-5180 D shall be met~~ medical necessity criteria shall continue to be met, and progress notes shall document the status of progress relative to the goals identified in the recovery, resiliency, and wellness plan.

g. Discharge criteria from mental health peer support services is the same as set forth in 12VAC30-130-5180 E.

h. Mental health peer support services shall be rendered on an individual basis or in a group.

i. Prior to service initiation, a documented recommendation for mental health peer support services shall be made by a licensed mental health professional acting within the scope of practice under state law The recommendation shall verify that the individual meets the medical necessity criteria set forth in subdivision 7 e of this subsection. The recommendation shall be valid for no longer than 30 calendar days.

j. Effective July 1, 2017, a peer recovery specialist shall have the qualifications, education, experience, and certification established by DBHDS in order to be eligible to register with the Board of Counseling on or after July 1, 2018. Upon the promulgation of regulations by the Board of Counseling, registration of peer recovery specialists by the Board of Counseling shall be required. The PRS shall perform mental health peer support services under the oversight of the LMHP making the recommendation for services and providing the clinical oversight of the recovery, resiliency, and wellness plan. The PRS shall be employed by or have a contractual relationship with an enrolled provider licensed for one of the following:

(1) Acute care general hospital licensed by the Department of Health.

(2) Freestanding psychiatric hospital and inpatient psychiatric unit licensed by the Department of Behavioral Health and Developmental Services.

(3) Outpatient mental health clinic services licensed by the Department of Behavioral Health and Developmental Services.

(4) Outpatient psychiatric services provider.

(5) Rural health clinics and federally qualified health centers.

(6) Hospital emergency department services licensed by the Department of Health.

(7) Community mental health and rehabilitative services provider licensed by the Department of Behavioral Health and Developmental Services as a provider of one of the following community mental health and rehabilitative services defined in this section or 12VAC30-50-420 for which the individual meets medical necessity criteria:

(a) Day treatment or partial hospitalization;

(b) Psychosocial rehabilitation;

(c) Crisis intervention;

(d) Intensive community treatment;

(e) Crisis stabilization;

(f) Mental health skill building; or

(g) Mental health case management.

k. Only the licensed and enrolled provider referenced in subdivision 7 j of this subsection shall be eligible to bill mental health peer support services. Payments shall not be permitted to providers that fail to enter into an enrollment agreement with DMAS or its contractor. Reimbursement shall be subject to retraction for any billed service that is determined to not to be in compliance with DMAS requirements.

l. Supervision of the PRS shall be required as set forth in ~~12VAC30-130-5190 E and 12VAC30-130-5200 G~~ the definition of "supervision" in 12VAC30-130-5160. Supervision of the PRS shall also meet the following requirements: the supervisor shall be under the clinical oversight of the LMHP making the recommendation for services, and the peer recovery specialist in consultation with his direct supervisor shall conduct and document a review of the recovery, resiliency, and wellness plan every 90 calendar days with the individual and the caregiver, as applicable. The review shall be signed by the PRS and the individual and, as applicable, the identified family member or caregiver. Review of the recovery, resiliency, and wellness plan means the PRS evaluates and updates the individual's progress every 90 days toward meeting the plan's goals and documents the outcome of this review in the individual's medical record. For DMAS to determine that these reviews are complete, the reviews shall (i) update the goals and objectives as needed to reflect any change in the individual's recovery as well as any newly identified needs, (ii) be conducted in a manner that enables the individual to actively participate in the process, and (iii) be documented by the PRS in the individual's medical record no later than 15 calendar days from the date of the review.

12VAC30-130-5170. Peer support services and family support partners: service definitions.

A. ARTS peer support services and ARTS family support partners are peer recovery support services and are nonclinical, peer-to-peer activities that engage, educate, and support an individual's, and as applicable the caregiver's, self-help efforts to improve health recovery, resiliency, and wellness. These services shall be available to either:

1. Individuals 21 years of age or older with mental health or substance use disorders or co-occurring mental health and substance use disorders that are the focus of the support; or

2. The caregiver of individuals younger than 21 years of age with mental health or substance use disorders or co-occurring mental health and substance use disorders that are the focus of the support.

3. Individuals 18 through 20 years of age who meet the medical necessity criteria set forth in 12VAC30-130-5180 A who would benefit from receiving peer supports directly, and who choose to receive ARTS peer support services directly instead of through their family shall be permitted to receive peer support services by an appropriate PRS.

B. ARTS peer support services for adults is a person centered, strength-based, and recovery-oriented rehabilitative service for individuals 21 years of age or older provided by a peer recovery specialist successful in the recovery process with lived experience with substance use disorders or co-occurring mental health and substance use disorders who is trained to offer support and assistance in helping others in recovery to reduce the disabling effects of a mental health or substance use disorder or co-occurring mental health and substance use disorder that is the focus of support. Services assist the individual with developing and maintaining a path to recovery, resiliency, and wellness. Specific peer support service activities shall emphasize the acquisition, development, and enhancement of recovery, resiliency, and wellness. Services are designed to promote empowerment, self-determination, understanding, and coping skills through mentoring and service coordination supports, as well as to assist individuals in achieving positive coping mechanisms for the stressors and barriers encountered when recovering from their illness or disorder.

C. ~~ARTS family~~ Family support partners is a peer support service and a strength-based, individualized service provided to the caregiver of a Medicaid-eligible individual younger than 21 years of age with a mental health or substance use disorder or co-occurring mental health and substance use disorder that is the focus of support. The services provided to the caregiver and the individual must be directed exclusively toward the benefit of the Medicaid-eligible individual. Services are expected to improve outcomes for an individual younger than 21 years of age with complex needs who is involved with multiple systems and increase the individual's and family's confidence and capacity to manage their own services and supports while promoting recovery and healthy relationships. These services are rendered by a PRS who is (i) a parent of a minor or adult child with a similar substance use disorder or co-occurring mental health and substance use disorder or (ii) an adult with personal experience with a family member with a similar mental health or substance use disorder or co-occurring mental health and substance use disorder with experience navigating substance use or behavioral health care services. The PRS shall perform the service within the scope of his knowledge, lived experience, and education.

D. ARTS peer support services shall be rendered on an individual basis or in a group.

12VAC30-130-5190. Peer support services and family support partners: provider and setting requirements.

A. Effective July 1, 2017, a peer recovery specialist shall have the qualifications, education, and experience established by DBHDS and show certification in good standing by the U.S. Department of Veterans Affairs, NAADAC - the Association of Addiction Professionals, a member board of the International Certification and Reciprocity Consortium, or any other certifying body or state certification with standards comparable to or higher than those specified by DBHDS to be eligible to register with the Board of Counseling on or after July 1, 2018. Upon the promulgation of regulations by the Board of Counseling, registration of peer recovery specialists by the Board of Counseling shall be required.

B. Prior to service initiation, a documented recommendation for service by a practitioner who meets clauses (i) through (xii) of the definition of "credentialed addiction treatment professional" found in 12VAC30-130-5020 and who is acting within his scope of practice under state law shall be required. A certified substance abuse counselor, as defined in § 54.1-3507.1 of the Code of Virginia, may also provide a documented recommendation for service if he is acting under the supervision or direction of a licensed substance use treatment practitioner or licensed mental health professional. The PRS shall perform ARTS peer services under the oversight of the practitioner described in this subsection making the recommendation for services and providing the clinical oversight of the recovery, resiliency, and wellness plan. The recommendation shall verify that the individual meets the medical necessity criteria set forth in 12VAC30-130-5180 A or B, as applicable.

C. The PRS shall be employed by or have a contractual relationship with the enrolled provider licensed for one of the following:

1. Acute care general hospital (ASAM Level 4.0) licensed by the Department of Health as defined in 12VAC30-130-5150.

2. Freestanding psychiatric hospital or inpatient psychiatric unit (ASAM Levels 3.5 and 3.7) licensed by the Department of Behavioral Health and Developmental Services as defined in 12VAC30-130-5130 and 12VAC30-130-5140.

3. Residential placements (ASAM Levels 3.1, 3.3, 3.5, and 3.7) licensed by the Department of Behavioral Health and Developmental Services as defined in 12VAC30-130-5110 through 12VAC30-130-5140.

4. ASAM Levels 2.1 and 2.5, licensed by the Department of Behavioral Health and Developmental Services as defined in 12VAC30-130-5090 and 12VAC30-130-5100.

5. ASAM Level 1.0 as defined in 12VAC30-30-5080.

6. Opioid treatment services as defined in 12VAC30-130-5050.

7. Office-based opioid treatment as defined in 12VAC30-130-5060.

8. Hospital emergency department services licensed by the Department of Health.

9. Pharmacy services licensed by the Department of Health.

D. Only a licensed and enrolled provider referenced in subsection C of this section shall be eligible to bill and receive reimbursement from DMAS or its contractor for ARTS peer support services. Payments shall not be permitted to providers that fail to enter into an enrollment agreement with DMAS or its contractor. Reimbursement shall be subject to retraction for any billed service that is determined to not to be in compliance with DMAS requirements.

E. The direct supervisor, as defined in 12VAC30-130-5160, shall perform direct supervision of the PRS as needed based on the level of urgency and intensity of service being provided. The direct supervisor shall have an employment or contract relationship with the same provider entity that employs or contracts with the PRS. Direct supervisors shall maintain documentation of all supervisory sessions. In no instance shall supervisory sessions be performed less than as provided below:

1. If the PRS has less than 12 months experience delivering ARTS peer support services or ARTS family support

partners, he shall receive face-to-face, one-to-one supervisory meetings of sufficient length to address identified challenges for a minimum of 30 minutes, two times a month. The direct supervisor must be available at least by telephone while the PRS is on duty.

2. If the PRS has been delivering ARTS peer recovery services over 12 months and fewer than 24 months, he must receive monthly face-to-face, one-to-one supervision of sufficient length to address identified challenges for a minimum of 30 minutes. The direct supervisor must be available by telephone for consult within 24 hours of service delivery if needed for challenging situations.

F. The caseload assignment of a full-time PRS shall not exceed ~~12 to~~ 15 individuals at any one time ~~and 30 to 40 individuals annually~~ allowing for new case assignments as those on the existing caseload begin to self-manage with less support. The caseload assignment of a part-time PRS shall not exceed ~~six to~~ nine individuals at any one time ~~and 15 annually~~. There are no minimum limits for full-time or part-time PRS caseloads.

VA.R. Doc. No. R19-5386; Filed December 12, 2018, 3:15 p.m.

Fast-Track Regulation

Title of Regulation: **12VAC30-130. Amount, Duration, and Scope of Selected Services (repealing 12VAC30-130-3000 through 12VAC30-130-3030).**

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

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: February 6, 2019.

Effective Date: February 21, 2019.

Agency Contact: Emily McClellan, Regulatory Supervisor, Policy Division, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-4300, FAX (804) 786-1680, or email emily.mcclellan@dmas.virginia.gov.

Basis: Section 32.1-325 of the Code of Virginia grants to the Board of Medical Assistance Services the authority to administer and amend the State Plan for Medical Assistance. Section 32.1-324 of the Code of Virginia authorizes the Director of the Department of Medical Assistance Services (DMAS) to administer and amend the State Plan for Medical Assistance according to the board's requirements. The Medicaid authority as established by § 1902(a) of the Social Security Act (42 USC § 1396a) provides governing authority for payments for services.

Purpose: This purpose of this action is to repeal the regulations associated with the Virginia Independent Clinical Assessment Program (VICAP), which ended on November 30, 2016. The action supports the public health, safety, and welfare by removing outdated, unnecessary regulations from the Virginia Administrative Code and providing improved access to care for qualified Medicaid members.

Rationale for Using Fast-Track Rulemaking Process: This regulatory action is being promulgated as a fast-track rulemaking action because it is not expected to be controversial. DMAS reduced the number of provider obligations when it ended the VICAP program, and repealing these regulations is a clean-up item.

Substance: VICAP was created in 2011 to better manage access to select Medicaid-funded community mental health rehabilitative (CMHR) services, such as intensive in-home, therapeutic day treatment, and mental health support services, for children and adults up to age 21. The community services boards (CSBs) served as partners with the Commonwealth, conducting VICAP assessments during the time period that the VICAP was required for service authorization of select CMHR services.

Based on a comprehensive review of the behavior health services administrator's (BHSA) administrative functions, which include medical necessity review, level of care assessments, and authorization of services, and a DMAS evaluation of data relative to VICAP assessments, it was determined in August 2016 that the VICAP was no longer needed to ensure appropriate access to services. Providers were notified in a DMAS Memorandum dated August 30, 2016, that the VICAP assessment would do longer be required as of December 1, 2016.

As of today, these functions are performed by the Commonwealth Coordinated Care Plus Medicaid managed care organizations for their enrolled members. The BHSA continues to perform these functions for individuals enrolled in fee-for-service and individuals enrolled in the Medallion 3.0 and Family Access to Medical Insurance Security programs, until those individuals are rolled into the Medallion 4.0 program, beginning on August 1, 2018.

Issues: The primary advantages of this action, to both the public and the agency, are the removal of outdated, unnecessary regulations from the Virginia Administrative Code and improved access to care for qualified Medicaid members.

These changes create no disadvantages to the public, the agency, the Commonwealth, or the regulated community.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The Board of Medical Assistance Services (Board) proposes to repeal the regulation for the Virginia Independent Clinical Assessment Program (VICAP).

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

Estimated Economic Impact. The board proposes to repeal the VICAP regulation. The VICAP was designed to better manage access to several Community Mental Health Rehabilitative Services (CMHRS) by requiring providers to obtain an independent clinical assessment to determine that these CMHRS services were clinically appropriate. These services were Intensive In-Home Services, Therapeutic Day Treatment, and Mental Health Skill Building for individuals up to the age of 21.

The VICAP was implemented in 2011 as an interim measure until the Department of Medical Assistance Services (DMAS) could finalize a contract with a behavioral health services administrator (BHSA). The community services boards (CSBs) were partners with the Commonwealth conducting VICAP assessments. In fiscal year 2016, a monthly average of 1,700 unique members were assessed for services at a cost of $5.2 million.

In a memo to providers dated August 30, 2016, DMAS concluded:[1]

> Based on a comprehensive review of Magellan's [BHSA] current administrative functions and the Department's evaluation of data relative to VICAP assessments, DMAS has determined that the VICAP is no longer needed to ensure appropriate access to services. Given Magellan's functions including medical necessity review, level of care assessment, and authorization of services, the role previously fulfilled by CSBs can now be fulfilled by Magellan within its existing process. Therefore, starting December 1, 2016, VICAP assessments will not be required to access Medicaid community mental health services and DMAS will not reimburse for VICAPs conducted on or after December 1, 2016.
>
> In lieu of a VICAP assessment, CMH providers will document medical necessity for each individual in accordance with specific service definitions as defined in the Magellan agreement and DMAS provider policy manuals.

Since the termination of the VICAP in 2016, as allowed in the budget mandates of Item 301 OO and Item 301 PP of Chapter 665 of the 2015 Acts of Assembly,[2] DMAS allocated the funds to be used in standardizing the care coordination requirements for individuals needing a residential level of care. This was the implementation of the Independent Assessment and Care Coordination Team (IACCT) on July 1, 2017.

DMAS has also been in the process of transitioning the CMHRS services into contracted Medicaid Managed Care Organizations (MCOs). Responsibility for the management of CMHRS services for individuals enrolled in Commonwealth Coordinated Care (CCC) Plus was transitioned from the BHSA to the CCC Plus MCOs on January 1, 2018. CMHR services were included in the Medicaid Managed Care Program, Medallion 4.0, beginning on August 1, 2018 with regional rollouts. Individuals enrolled in the Medallion 3.0 Managed Care program and the Family Access to Medical Insurance Security (FAMIS) program will transition to Medallion 4.0 statewide by December 31, 2018.

Since the VICAP was effectively terminated in 2016, the repeal of this regulation is not expected to create any economic impact upon promulgation beyond improving the consistency between the regulatory language and the current practice. When the termination was implemented in 2016, however, VICAP expenditures received by CSBs until that time were effectively redirected to the contracted BHSA to help fund the IACCT process for children needing residential treatment. The BHSA, and starting January 1, 2018, the Medicaid MCOs are now fulfilling the functions including medical necessity review, level of care assessment and authorization of services.

Businesses and Entities Affected. The proposed repeal of the regulation is not expected to affect any specific entity upon promulgation but likely to benefit the public and the providers by improving the consistency between practice and regulatory language.

Localities Particularly Affected. The proposed regulation does not disproportionately affect particular localities.

Projected Impact on Employment. No impact on employment is expected upon promulgation.

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

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

Small Businesses:

Definition. Pursuant to § 2.2-4007.04 of the Code of Virginia, small business is defined as "a business entity, including its affiliates, that (i) is independently owned and operated and (ii) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million."

Costs and Other Effects

The proposed regulation will not have costs and other effects on small businesses upon promulgation.

Alternative Method that Minimizes Adverse Impact. The proposed regulation will not adversely affect small businesses upon promulgation.

Adverse Impacts:

Businesses. The proposed regulation will not adversely affect businesses upon promulgation.

Localities. The proposed regulation will not adversely affect localities upon promulgation.

Other Entities. The proposed regulation will not adversely affect other entities upon promulgation.

[1]https://www.ecm.virginiamedicaid.dmas.virginia.gov/WorkplaceXT/getContent?impersonate=true&id=%7b78F5CC12-BA98-48C8-9429-084A813E1976%7d&vsId=%7bB114AB78-512B-42F6-ACD9-F87A630D8C54%7d&objectType=document&objectStoreName=VAPRODOS1

[2]https://budget.lis.virginia.gov/item/2015/1/HB1400/Chapter/1/301/

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

Summary:

The action repeals the regulations associated with the Virginia Independent Clinical Assessment Program, which ended on November 30, 2016.

~~Part XVIII~~
~~Behavioral Health Services~~ (Repeal)

12VAC30-130-3000. ~~Behavioral health services.~~ (Repealed.)

~~A. Behavioral health services that shall be covered only for individuals from birth through 21 years of age are set out in 12VAC30-50-130 B 5 and include: (i) intensive in-home services (IIH), (ii) therapeutic day treatment (TDT), (iii) community based services for children and adolescents (Level A), and (iv) therapeutic behavioral services (Level B).~~

~~B. Behavioral health services that shall be covered for individuals regardless of age are set out in 12VAC30-50-226 and include: (i) day treatment/partial hospitalization, (ii) psychosocial rehabilitation, (iii) crisis intervention, (iv) case management as set out in 12VAC30-50-420 and 12VAC30-50-430, (v) intensive community treatment (ICT), (vi) crisis stabilization services, and (vii) mental health support services (MHSS).~~

12VAC30-130-3010. ~~Definitions.~~ (Repealed.)

~~The following words and terms when used in these regulations shall have the following meanings unless the context clearly indicates otherwise:~~

~~"Behavioral health authority" or "BHA" means the local agency that administers services set out in § 37.2-601 of the Code of Virginia.~~

~~"Behavioral health services administrator" or "BHSA" means an entity that manages or directs a behavioral health benefits program under contract with DMAS.~~

~~"Community services board" or "CSB" means the local agency that administers services set out in § 37.2-500 of the Code of Virginia.~~

~~"DMAS" means the Department of Medical Assistance Services.~~

~~"Independent assessor" means a professional who performs the independent clinical assessment who may be employed by either the behavioral health services administrator, community services boards/behavioral health authorities (CSBs/BHAs) or their subcontractors.~~

~~"Independent clinical assessment" or "ICA" means the assessment that is performed under contract with DMAS either by the behavioral health services administrator or the CSB/BHA, or its subcontractor, prior to the initiation of (i) intensive in-home (IIH) services or therapeutic day treatment (TDT) as set out in 12VAC30-50-130 and (ii) mental health support services (MHSS) for children and adolescents (MHSS) as set out in 12VAC30-50-226.~~

~~"VICAP" means the form entitled Virginia Independent Clinical Assessment Program that is required to record an individual's independent clinical assessment information.~~

12VAC30-130-3020. ~~Independent clinical assessment requirements; behavioral health level of care determinations and service eligibility.~~ (Repealed.)

~~A. The independent clinical assessment (ICA), as set forth in the Virginia Independent Assessment Program (VICAP-001) form, shall contain the Medicaid individual-specific elements of information and data that shall be required for an individual younger than the age of 21 to be approved for intensive in-home (IIH) services, therapeutic day treatment (TDT), or mental health support services (MHSS) or any combination thereof. Eligibility requirements for IIH are in 12VAC30-50-130 B 5 b. Eligibility requirements for TDT are in 12VAC30-50-130 B 5 c. Eligibility requirements for MHSS are in 12VAC30-50-226 B 8.~~

~~1. The required elements in the ICA shall be specified in the VICAP form with either the BHSA or CSBs/BHAs and DMAS.~~

~~2. Service recommendations set out in the ICA shall not be subject to appeal.~~

~~B. Independent clinical assessment requirements.~~

~~1. Effective July 18, 2011, an ICA shall be required as a part of the service authorization process for Medicaid and Family Access to Medical Insurance Security (FAMIS) intensive in-home (IIH) services, therapeutic day treatment (TDT), or mental health support services (MHSS) for individuals up to the age of 21. This ICA shall be performed prior to the request for service authorization and initiation of treatment for individuals who are not currently receiving or authorized for services. The ICA shall be completed prior to the service provider conducting an intake or providing treatment.~~

a. Each individual shall have at least one ICA prior to the initiation of either IIH or TDT, or MHSS for individuals up to the age of 21.

b. For individuals who are already receiving IIH services or TDT, or MHSS, as of July 18, 2011, the requirement for a completed ICA shall be effective for service reauthorizations for dates of services on and after September 1, 2011.

c. Individuals who are being discharged from residential treatment (DMAS service Levels A, B, or C) or inpatient psychiatric hospitalization do not need an ICA prior to receiving community IIH services or TDT, or MHSS. They shall be required, however, to have an ICA as part of the first subsequent service reauthorization for IIH services, TDT, MHSS, or any combination thereof.

2. The ICA shall be completed and submitted to DMAS or its service authorization contractor by the independent assessor prior to the service provider submitting the service authorization or reauthorization request to the DMAS service authorization contractor. Failure to meet these requirements shall result in the provider's service authorization or reauthorization request being returned to the provider.

3. A copy of the ICA shall be retained in the service provider's individual's file.

4. If a service provider receives a request from parents or legal guardians to provide IIH services, TDT, or MHSS for individuals who are younger than 21 years of age, the service provider shall refer the parent or legal guardian to the BHSA or the local CSB/BHA to obtain the ICA prior to providing services.

a. In order to provide services, the service provider shall be required to conduct a service specific provider intake as defined in 12VAC30-50-130.

b. If the selected service provider concurs that the child meets criteria for the service recommended by the independent assessor, the selected service provider shall submit a service authorization request to DMAS service authorization contractor. The service specific provider's intake for IIH services, TDT, or MHSS shall not occur prior to the completion of the ICA by the BHSA or CSB/BHA, or its subcontractor.

c. If within 30 days after the ICA a service provider identifies the need for services that were not recommended by the ICA, the service provider shall contact the independent assessor and request a modification. The request for a modification shall be based on a significant change in the individual's life that occurred after the ICA was conducted. Examples of a significant change may include, but shall not be limited to, hospitalization; school suspension or expulsion; death of a significant other; or hospitalization or incarceration of a parent or legal guardian.

d. If the independent assessment is greater than 30 days old, a new ICA must be obtained prior to the initiation of IIH services, TDT, or MHSS for individuals younger than 21 years of age.

e. If the parent or legal guardian disagrees with the ICA recommendation, the parent or legal guardian may appeal the recommendation in accordance with Part I (12VAC30-110-10 et seq.) In the alternative, the parent or legal guardian may request that a service provider perform his own evaluation. If after conducting a service-specific provider intake the service provider identifies additional documentation previously not submitted for the ICA that demonstrates the service is medically necessary and clinically indicated, the service provider may submit the supplemental information with a service authorization request to the DMAS service authorization contractor. The DMAS service authorization contractor will review the service authorization submission and the ICA and make a determination. If the determination results in a service denial, the individual, parent or legal guardian, and service provider will be notified of the decision and their appeal rights pursuant to Part I (12VAC30-110-10 et seq.).

5. If the individual is in immediate need of treatment, the independent clinical assessor shall refer the individual to the appropriate enrolled Medicaid emergency services providers in accordance with 12VAC30-50-226 and shall also alert the individual's managed care organization.

C. Requirements for behavioral health services administrator and community services boards/behavioral health authorities.

1. When the BHSA, CSB, or BHA has been contacted by the parent or legal guardian, the ICA appointment shall be offered within five business days of a request for IIH services and within 10 business days for a request for TDT or MHSS, or both. The appointment may be scheduled beyond the respective time frame at the documented request of the parent or legal guardian.

2. The independent assessor shall conduct the ICA with the individual and the parent or legal guardian using the VICAP-001 form and make a recommendation for the most appropriate medically necessary services, if indicated. Referring or treating providers shall not be present during the assessment but may submit supporting clinical documentation to the assessor.

3. The ICA shall be effective for a 30-day period.

4. The independent assessor shall enter the findings of the ICA into the DMAS service authorization contractor's web portal within one business day of conducting the assessment. The independent clinical assessment form

~~(VICAP 001) shall be completed by the independent assessor within three business days of completing the ICA.~~

~~D. The individual or his parent or legal guardian shall have the right to freedom of choice of service providers.~~

12VAC30-130-3030. ~~Application to services.~~ (Repealed.)

~~A. Intensive in-home (IIH) services.~~

~~1. Prior to the provision of IIH services, an independent clinical assessment shall be conducted by a person who meets the licensed mental health professional definition found at 12VAC35-105-20 and who is either employed by or contracted with a behavioral health services administrator (BHSA), community services board (CSB), behavioral health authority (BHA), or a subcontractor to the BHSA, CSB, or BHA in accordance with DMAS approval.~~

~~2. IIH services that are rendered in the absence of the required prior independent clinical assessment shall not be reimbursed.~~

~~B. Therapeutic day treatment (TDT) services.~~

~~1. Prior to the provision of TDT services, an independent clinical assessment shall be conducted by a person who meets the licensed mental health professional definition found at 12VAC35-105-20 and who is employed by or contracted with a BHSA, CSB, BHA, or the subcontractor of the BHSA, CSB, or BHA in accordance with DMAS approval.~~

~~2. TDT services that are rendered in the absence of the required prior independent clinical assessment shall not be reimbursed.~~

~~C. Mental health support services (MHSS).~~

~~1. Prior to the provision of MHSS, an independent clinical assessment, as defined in 12VAC30-130-3010, shall be conducted by a person who meets the licensed mental health professional definition found at 12VAC35-105-20 and who is employed by or contracted with a BHSA, CSB or BHA, or a subcontractor of a BHSA, CSB, or BHA in accordance with DMAS approval.~~

~~2. MHSS rendered in the absence of the required prior independent clinical assessment shall not be reimbursed.~~

~~D. Other Medicaid-covered community mental health services. DMAS may apply the independent clinical assessment requirement to any of the other Medicaid-covered community mental health services set out in 12VAC30-50-130 and 12VAC30-50-226 with appropriate and timely notice to providers. In such situations, DMAS shall not deny coverage to providers' claims for these affected services absent at least a 30-day notice of this change.~~

VA.R. Doc. No. R19-5568; Filed December 12, 2018, 3:53 p.m.

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

Fast-Track Regulation

Title of Regulation: **12VAC35-105. Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services (amending 12VAC35-105-20).**

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

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: February 6, 2019.

Effective Date: February 21, 2019.

Agency Contact: Emily Bowles, Legal Coordinator, Office of Licensing, Department of Behavioral Health and Developmental Services, 1220 Bank Street, P.O. Box 1797, Richmond, VA 23218, telephone (804) 225-3281, FAX (804) 692-0066, TTY (804) 371-8977, or email emily.bowles@dbhds.virginia.gov.

Basis: Sections 37.2-203 and 37.2-304 of the Code of Virginia authorize the Board of Behavioral Health and Development Services to adopt regulations that may be necessary to carry out the provisions of Title 37.2 of the Code of Virginia and other laws of the Commonwealth administered by the Commissioner and the Department of Behavioral Health and Development Services.

Purpose: This change is made at the request of the Department of Medical Assistance Services to create alignment between that agency's regulations and 12VAC35-105 for all staff qualifications for reimbursement purposes.

Psychiatric and mental health nurse practitioners work with mental health patients of all ages and may specialize in a specific age population. A licensed psychiatric/mental health nurse practitioner (PMHNP) can practice in a variety of locations including, but not limited to, in-patient psychiatric facilities, state psychiatric facilities, correctional facilities, mental health centers, home health locations, and schools. By adding this profession to the definition of who can be considered a licensed mental health practitioner, it facilitates more trained professionals to be available to provide services.

Rationale for Using Fast-Track Rulemaking Process: The amendments are noncontroversial. One nursing category is already included in the definition (certified psychiatric clinical nurse specialist); this newly added category is similar but distinct from the clinical nurse specialist. The Medicaid funding stream for reimbursement of services is available to both categories.

Substance: The current licensing regulations are amended to read as follows:

"Licensed mental health professional (LMHP)" means a physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, certified psychiatric clinical nurse specialist, licensed behavioral analyst, or licensed psychiatric/mental health nurse practitioner.

Issues: There are no identified disadvantages to the public or the Commonwealth in making this change. By adding this profession to the definition of who can be considered an LMHP, more trained professionals are available to provide services. This is an advantage to PMHNPs and individuals in need of services because it opens the Medicaid funding stream for reimbursement of services.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. Pursuant to a request from the Department of Medical Assistance Services (DMAS), the State Board of Behavioral Health and Developmental Services (Board) proposes to add "licensed psychiatric/mental health nurse practitioner" to the list of professions within the definition of licensed mental health professional (LMHP).

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

Estimated Economic Impact. Department of Behavioral Health and Developmental Services (DBHDS) regulations require supervision of mental health, substance abuse, or co-occurring services that are of an acute or clinical nature such as outpatient, inpatient, intensive in-home, or day treatment to be provided by an LMHP or a mental health professional who is license-eligible and registered with a board of the Department of Health Professions. DBHDS regulations currently include the following professions as LMHPs: physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, or certified psychiatric clinical nurse specialist.

Adding licensed psychiatric/mental health nurse practitioner (PMHNP) to the definition of licensed mental health professionals would allow PMHNPs to supervise and shape services and to effectively include their practice methods into the services provided to individuals. PMHNPs would be able to supervise and direct courses of treatment for individuals receiving mental health, substance abuse, or concurring services that are of an acute or clinical nature. This would enable service providers more options for staff that can supervise direct courses of treatment. PMHNPs may only supervise work that falls within their scope of practice.

Allowing providers more options for staff who can supervise direct courses of treatment would be beneficial for providers. Enabling PMHNPs to perform work that the current regulation does not permit would be beneficial for these professionals. Since PMHNPs may only supervise work that falls within their scope of practice, there is no increased risk to patients. Thus, the proposed amendment would likely produce a net benefit.

Businesses and Entities Affected. The proposed amendment potentially affects the approximate 1,300 licensed service providers,[1] 363 PMHNPs, and patients served by the service providers. The majority of the service providers would qualify as a small business.[2]

Localities Particularly Affected. The proposed amendment does not disproportionately affect particular localities.

Projected Impact on Employment. The proposed amendment may increase employment opportunities for PMHNPs.

Effects on the Use and Value of Private Property. The proposed amendment may increase demand for services from PMHNPs. Consequently, the value of firms that employ PMHNPs may moderately increase.

Real Estate Development Costs. The proposed amendment does not affect real estate development costs.

Small Businesses:

Definition. Pursuant to § 2.2-4007.04 of the Code of Virginia, small business is defined as "a business entity, including its affiliates, that (i) is independently owned and operated and (ii) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million."

Costs and Other Effects. By allowing providers more options for staff who can supervise direct courses of treatment, the proposed amendment may reduce costs for some small service providers.

Alternative Method that Minimizes Adverse Impact. The proposed amendment does not adversely affect small businesses.

Adverse Impacts:

Businesses. The proposed amendment does not adversely affect businesses.

Localities. The proposed amendment does not adversely affect localities.

Other Entities. The proposed amendment does not adversely affect other entities.

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[1]Provider is defined as "any person, entity, or organization, excluding an agency of the federal government by whatever name or designation, that delivers (i) services to individuals with mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders), (ii) services to individuals who receive day support, in-home support, or crisis

stabilization services funded through the IFDDS Waiver, or (iii) residential services for individuals with brain injury…" See https://law.lis.virginia.gov/admincode/title12/agency35/chapter105/section20/. Not all providers use LMHPs.

[2]Data Source: Department of Behavioral Health and Developmental Services

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

Summary:

The amendment adds licensed psychiatric/mental health nurse practitioner to the definition of "licensed mental health professional."

Article 2
Definitions

12VAC35-105-20. Definitions.

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

"Abuse" (§ 37.2-100 of the Code of Virginia) means any act or failure to act by an employee or other person responsible for the care of an individual in a facility or program operated, licensed, or funded by the department, excluding those operated by the Virginia Department of Corrections, that was performed or was failed to be performed knowingly, recklessly, or intentionally, and that caused or might have caused physical or psychological harm, injury, or death to a person receiving care or treatment for mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders). Examples of abuse include acts such as:

1. Rape, sexual assault, or other criminal sexual behavior;

2. Assault or battery;

3. Use of language that demeans, threatens, intimidates, or humiliates the person;

4. Misuse or misappropriation of the person's assets, goods, or property;

5. Use of excessive force when placing a person in physical or mechanical restraint;

6. Use of physical or mechanical restraints on a person that is not in compliance with federal and state laws, regulations, and policies, professional accepted standards of practice, or the person's individualized services plan;

7. Use of more restrictive or intensive services or denial of services to punish the person or that is not consistent with his individualized services plan.

"Activities of daily living" or "ADLs" means personal care activities and includes bathing, dressing, transferring, toileting, grooming, hygiene, feeding, and eating. An individual's degree of independence in performing these activities is part of determining the appropriate level of care and services.

"Admission" means the process of acceptance into a service as defined by the provider's policies.

"Authorized representative" means a person permitted by law or 12VAC35-115 to authorize the disclosure of information or consent to treatment and services or participation in human research.

"Behavior intervention" means those principles and methods employed by a provider to help an individual receiving services to achieve a positive outcome and to address challenging behavior in a constructive and safe manner. Behavior intervention principles and methods must be employed in accordance with the individualized services plan and written policies and procedures governing service expectations, treatment goals, safety, and security.

"Behavioral treatment plan," "functional plan," or "behavioral support plan" means any set of documented procedures that are an integral part of the individualized services plan and are developed on the basis of a systematic data collection, such as a functional assessment, for the purpose of assisting individuals to achieve the following:

1. Improved behavioral functioning and effectiveness;

2. Alleviation of symptoms of psychopathology; or

3. Reduction of challenging behaviors.

"Brain injury" means any injury to the brain that occurs after birth, but before age 65, that is acquired through traumatic or nontraumatic insults. Nontraumatic insults may include anoxia, hypoxia, aneurysm, toxic exposure, encephalopathy, surgical interventions, tumor, and stroke. Brain injury does not include hereditary, congenital, or degenerative brain disorders or injuries induced by birth trauma.

"Care" or "treatment" means the individually planned therapeutic interventions that conform to current acceptable professional practice and that are intended to improve or maintain functioning of an individual receiving services delivered by a provider.

"Case management service" means services that can include assistance to individuals and their family members in assessing needed services that are responsive to the person's individual needs. Case management services include: identifying potential users of the service; assessing needs and planning services; linking the individual to services and supports; assisting the individual directly to locate, develop, or obtain needed services and resources; coordinating services with other providers; enhancing community integration; making collateral contacts; monitoring service delivery; discharge planning; and advocating for individuals in response to their changing needs. "Case management service"

does not include maintaining service waiting lists or periodically contacting or tracking individuals to determine potential service needs.

"Clinical experience" means providing direct services to individuals with mental illness or the provision of direct geriatric services or special education services. Experience may include supervised internships, practicums, and field experience.

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

"Community gero-psychiatric residential services" means 24-hour care provided to individuals with mental illness, behavioral problems, and concomitant health problems who are usually age 65 or older in a geriatric setting that is less intensive than a psychiatric hospital but more intensive than a nursing home or group home. Services include assessment and individualized services planning by an interdisciplinary services team, intense supervision, psychiatric care, behavioral treatment planning and behavior interventions, nursing, and other health related services.

"Community intermediate care facility/mental retardation (ICF/MR)" means a residential facility in which care is provided to individuals who have mental retardation (intellectual disability) or a developmental disability who need more intensive training and supervision than may be available in an assisted living facility or group home. Such facilities shall comply with Title XIX of the Social Security Act standards and federal certification requirements, provide health or rehabilitative services, and provide active treatment to individuals receiving services toward the achievement of a more independent level of functioning or an improved quality of life.

"Complaint" means an allegation of a violation of these regulations or a provider's policies and procedures related to these regulations.

"Co-occurring disorders" means the presence of more than one and often several of the following disorders that are identified independently of one another and are not simply a cluster of symptoms resulting from a single disorder: mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders); brain injury; or developmental disability.

"Co-occurring services" means individually planned therapeutic treatment that addresses in an integrated concurrent manner the service needs of individuals who have co-occurring disorders.

"Corrective action plan" means the provider's pledged corrective action in response to cited areas of noncompliance documented by the regulatory authority. A corrective action plan must be completed within a specified time.

"Correctional facility" means a facility operated under the management and control of the Virginia Department of Corrections.

"Crisis" means a deteriorating or unstable situation often developing suddenly or rapidly that produces acute, heightened, emotional, mental, physical, medical, or behavioral distress; or any situation or circumstance in which the individual perceives or experiences a sudden loss of his ability to use effective problem-solving and coping skills.

"Crisis stabilization" means direct, intensive nonresidential or residential direct care and treatment to nonhospitalized individuals experiencing an acute crisis that may jeopardize their current community living situation. Crisis stabilization is intended to avert hospitalization or rehospitalization; provide normative environments with a high assurance of safety and security for crisis intervention; stabilize individuals in crisis; and mobilize the resources of the community support system, family members, and others for ongoing rehabilitation and recovery.

"Day support service" means structured programs of activity or training services for adults with an intellectual disability or a developmental disability, generally in clusters of two or more continuous hours per day provided to groups or individuals in nonresidential community-based settings. Day support services may provide opportunities for peer interaction and community integration and are designed to enhance the following: self-care and hygiene, eating, toileting, task learning, community resource utilization, environmental and behavioral skills, social skills, medication management, prevocational skills, and transportation skills. The term "day support service" does not include services in which the primary function is to provide employment-related services, general educational services, or general recreational services.

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

"Developmental disabilities" means autism or a severe, chronic disability that meets all of the following conditions identified in 42 CFR 435.1009:

1. Attributable to cerebral palsy, epilepsy, or any other condition, other than mental illness, that is found to be closely related to mental retardation (intellectual disability) because this condition results in impairment of general intellectual functioning or adaptive behavior similar to behavior of individuals with mental retardation (intellectual disability) and requires treatment or services similar to those required for these individuals;

2. Manifested before the individual reaches age 18;

3. Likely to continue indefinitely; and

4. Results in substantial functional limitations in three or more of the following areas of major life activity:

a. Self-care;

b. Understanding and use of language;

c. Learning;

d. Mobility;

e. Self-direction; or

f. Capacity for independent living.

"Discharge" means the process by which the individual's active involvement with a service is terminated by the provider, individual, or authorized representative.

"Discharge plan" means the written plan that establishes the criteria for an individual's discharge from a service and identifies and coordinates delivery of any services needed after discharge.

"Dispense" means to deliver a drug to an ultimate user by or pursuant to the lawful order of a practitioner, including the prescribing and administering, packaging, labeling or compounding necessary to prepare the substance for that delivery. (§ 54.1-3400 et seq. of the Code of Virginia.)

"Emergency service" means unscheduled and sometimes scheduled crisis intervention, stabilization, and referral assistance provided over the telephone or face-to-face, if indicated, available 24 hours a day and seven days per week. Emergency services also may include walk-ins, home visits, jail interventions, and preadmission screening activities associated with the judicial process.

"Group home or community residential service" means a congregate service providing 24-hour supervision in a community-based home having eight or fewer residents. Services include supervision, supports, counseling, and training in activities of daily living for individuals whose individualized services plan identifies the need for the specific types of services available in this setting.

"Home and noncenter based" means that a service is provided in the individual's home or other noncenter-based setting. This includes noncenter-based day support, supportive in-home, and intensive in-home services.

"IFDDS Waiver" means the Individual and Family Developmental Disabilities Support Waiver.

"Individual" or "individual receiving services" means a person receiving services that are licensed under this chapter whether that person is referred to as a patient, consumer, client, resident, student, individual, recipient, family member, relative, or other term. When the term is used, the requirement applies to every individual receiving licensed services from the provider.

"Individualized services plan" or "ISP" means a comprehensive and regularly updated written plan that describes the individual's needs, the measurable goals and objectives to address those needs, and strategies to reach the individual's goals. An ISP is person-centered, empowers the individual, and is designed to meet the needs and preferences of the individual. The ISP is developed through a partnership between the individual and the provider and includes an individual's treatment plan, habilitation plan, person-centered plan, or plan of care, which are all considered individualized service plans.

"Initial assessment" means an assessment conducted prior to or at admission to determine whether the individual meets the service's admission criteria; what the individual's immediate service, health, and safety needs are; and whether the provider has the capability and staffing to provide the needed services.

"Inpatient psychiatric service" means intensive 24-hour medical, nursing, and treatment services provided to individuals with mental illness or substance abuse (substance use disorders) in a hospital as defined in § 32.1-123 of the Code of Virginia or in a special unit of such a hospital.

"Instrumental activities of daily living" or "IADLs" means meal preparation, housekeeping, laundry, and managing money. A person's degree of independence in performing these activities is part of determining appropriate level of care and services.

"Intensive Community Treatment (ICT) service" means a self-contained interdisciplinary team of at least five full-time equivalent clinical staff, a program assistant, and a full-time psychiatrist that:

1. Assumes responsibility for directly providing needed treatment, rehabilitation, and support services to identified individuals with severe and persistent mental illness especially those who have severe symptoms that are not effectively remedied by available treatments or who because of reasons related to their mental illness resist or avoid involvement with mental health services;

2. Minimally refers individuals to outside service providers;

3. Provides services on a long-term care basis with continuity of caregivers over time;

4. Delivers 75% or more of the services outside program offices; and

5. Emphasizes outreach, relationship building, and individualization of services.

"Intensive in-home service" means family preservation interventions for children and adolescents who have or are at-risk of serious emotional disturbance, including individuals who also have a diagnosis of mental retardation (intellectual disability). Intensive in-home service is usually time-limited and is provided typically in the residence of an individual who is at risk of being moved to out-of-home placement or who is being transitioned back home from an out-of-home

placement. The service includes 24-hour per day emergency response; crisis treatment; individual and family counseling; life, parenting, and communication skills; and case management and coordination with other services.

"Investigation" means a detailed inquiry or systematic examination of the operations of a provider or its services regarding an alleged violation of regulations or law. An investigation may be undertaken as a result of a complaint, an incident report, or other information that comes to the attention of the department.

"Licensed mental health professional" or "LMHP" means a physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, certified psychiatric clinical nurse specialist, ~~or~~ licensed behavior analyst, or licensed psychiatric/mental health nurse practitioner.

"Location" means a place where services are or could be provided.

"Medically managed withdrawal services" means detoxification services to eliminate or reduce the effects of alcohol or other drugs in the individual's body.

"Mandatory outpatient treatment order" means an order issued by a court pursuant to § 37.2-817 of the Code of Virginia.

"Medical detoxification" means a service provided in a hospital or other 24-hour care facility under the supervision of medical personnel using medication to systematically eliminate or reduce effects of alcohol or other drugs in the individual's body.

"Medical evaluation" means the process of assessing an individual's health status that includes a medical history and a physical examination of an individual conducted by a licensed medical practitioner operating within the scope of his license.

"Medication" means prescribed or over-the-counter drugs or both.

"Medication administration" means the direct application of medications by injection, inhalation, ingestion, or any other means to an individual receiving services by (i) persons legally permitted to administer medications or (ii) the individual at the direction and in the presence of persons legally permitted to administer medications.

"Medication assisted treatment (Opioid treatment service)" means an intervention strategy that combines outpatient treatment with the administering or dispensing of synthetic narcotics, such as methadone or buprenorphine (suboxone), approved by the federal Food and Drug Administration for the purpose of replacing the use of and reducing the craving for opioid substances, such as heroin or other narcotic drugs.

"Medication error" means an error in administering a medication to an individual and includes when any of the following occur: (i) the wrong medication is given to an individual, (ii) the wrong individual is given the medication, (iii) the wrong dosage is given to an individual, (iv) medication is given to an individual at the wrong time or not at all, or (v) the wrong method is used to give the medication to the individual.

"Medication storage" means any area where medications are maintained by the provider, including a locked cabinet, locked room, or locked box.

"Mental Health Community Support Service (MHCSS)" means the provision of recovery-oriented services to individuals with long-term, severe mental illness. MHCSS includes skills training and assistance in accessing and effectively utilizing services and supports that are essential to meeting the needs identified in the individualized services plan and development of environmental supports necessary to sustain active community living as independently as possible. MHCSS may be provided in any setting in which the individual's needs can be addressed, skills training applied, and recovery experienced.

"Mental illness" means a disorder of thought, mood, emotion, perception, or orientation that significantly impairs judgment, behavior, capacity to recognize reality, or ability to address basic life necessities and requires care and treatment for the health, safety, or recovery of the individual or for the safety of others.

"Mental retardation (intellectual disability)" means a disability originating before the age of 18 years characterized concurrently by (i) significantly subaverage intellectual functioning as demonstrated by performance on a standardized measure of intellectual functioning administered in conformity with accepted professional practice that is at least two standard deviations below the mean; and (ii) significant limitations in adaptive behavior as expressed in conceptual, social, and practical adaptive skills (§ 37.2-100 of the Code of Virginia).

"Neglect" means the failure by an individual or a program or facility operated, licensed, or funded by the department, excluding those operated by the Department of Corrections, responsible for providing services to do so, including nourishment, treatment, care, goods, or services necessary to the health, safety, or welfare of a person receiving care or treatment for mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders).

"Neurobehavioral services" means the assessment, evaluation, and treatment of cognitive, perceptual, behavioral, and other impairments caused by brain injury that affect an individual's ability to function successfully in the community.

"Outpatient service" means treatment provided to individuals on an hourly schedule, on an individual, group, or

family basis, and usually in a clinic or similar facility or in another location. Outpatient services may include diagnosis and evaluation, screening and intake, counseling, psychotherapy, behavior management, psychological testing and assessment, laboratory and other ancillary services, medical services, and medication services. "Outpatient service" specifically includes:

1. Services operated by a community services board or a behavioral health authority established pursuant to Chapter 5 (§ 37.2-500 et seq.) or Chapter 6 (§ 37.2-600 et seq.) of Title 37.2 of the Code of Virginia;

2. Services contracted by a community services board or a behavioral health authority established pursuant to Chapter 5 (§ 37.2-500 et seq.) or Chapter 6 (§ 37.2-600 et seq.) of Title 37.2 of the Code of Virginia; or

3. Services that are owned, operated, or controlled by a corporation organized pursuant to the provisions of either Chapter 9 (§ 13.1-601 et seq.) or Chapter 10 (§ 13.1-801 et seq.) of Title 13.1 of the Code of Virginia.

"Partial hospitalization service" means time-limited active treatment interventions that are more intensive than outpatient services, designed to stabilize and ameliorate acute symptoms, and serve as an alternative to inpatient hospitalization or to reduce the length of a hospital stay. Partial hospitalization is focused on individuals with serious mental illness, substance abuse (substance use disorders), or co-occurring disorders at risk of hospitalization or who have been recently discharged from an inpatient setting.

"Person-centered" means focusing on the needs and preferences of the individual; empowering and supporting the individual in defining the direction for his life; and promoting self-determination, community involvement, and recovery.

"Program of Assertive Community Treatment (PACT) service" means a self-contained interdisciplinary team of at least 10 full-time equivalent clinical staff, a program assistant, and a full- or part-time psychiatrist that:

1. Assumes responsibility for directly providing needed treatment, rehabilitation, and support services to identified individuals with severe and persistent mental illnesses, including those who have severe symptoms that are not effectively remedied by available treatments or who because of reasons related to their mental illness resist or avoid involvement with mental health services;

2. Minimally refers individuals to outside service providers;

3. Provides services on a long-term care basis with continuity of caregivers over time;

4. Delivers 75% or more of the services outside program offices; and

5. Emphasizes outreach, relationship building, and individualization of services.

"Provider" means any person, entity, or organization, excluding an agency of the federal government by whatever name or designation, that delivers (i) services to individuals with mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders), (ii) services to individuals who receive day support, in-home support, or crisis stabilization services funded through the IFDDS Waiver, or (iii) residential services for individuals with brain injury. The person, entity, or organization shall include a hospital as defined in § 32.1-123 of the Code of Virginia, community services board, behavioral health authority, private provider, and any other similar or related person, entity, or organization. It shall not include any individual practitioner who holds a license issued by a health regulatory board of the Department of Health Professions or who is exempt from licensing pursuant to §§ 54.1-2901, 54.1-3001, 54.1-3501, 54.1-3601 and 54.1-3701 of the Code of Virginia.

"Psychosocial rehabilitation service" means a program of two or more consecutive hours per day provided to groups of adults in a nonresidential setting. Individuals must demonstrate a clinical need for the service arising from a condition due to mental, behavioral, or emotional illness that results in significant functional impairments in major life activities. This service provides education to teach the individual about mental illness, substance abuse, and appropriate medication to avoid complication and relapse and opportunities to learn and use independent skills and to enhance social and interpersonal skills within a consistent program structure and environment. Psychosocial rehabilitation includes skills training, peer support, vocational rehabilitation, and community resource development oriented toward empowerment, recovery, and competency.

"Qualified Mental Health Professional-Adult (QMHP-A)" means a person in the human services field who is trained and experienced in providing psychiatric or mental health services to individuals who have a mental illness; including (i) a doctor of medicine or osteopathy licensed in Virginia; (ii) a doctor of medicine or osteopathy, specializing in psychiatry and licensed in Virginia; (iii) an individual with a master's degree in psychology from an accredited college or university with at least one year of clinical experience; (iv) a social worker: an individual with at least a bachelor's degree in human services or related field (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services counseling or other degree deemed equivalent to those described) from an accredited college and with at least one year of clinical experience providing direct services to individuals with a diagnosis of mental illness; (v) a person with at least a bachelor's degree from an accredited college in an unrelated field that includes at least 15 semester credits (or equivalent) in a human

services field and who has at least three years of clinical experience; (vi) a Certified Psychiatric Rehabilitation Provider (CPRP) registered with the United States Psychiatric Rehabilitation Association (USPRA); (vii) a registered nurse licensed in Virginia with at least one year of clinical experience; or (viii) any other licensed mental health professional.

"Qualified Mental Health Professional-Child (QMHP-C)" means a person in the human services field who is trained and experienced in providing psychiatric or mental health services to children who have a mental illness. To qualify as a QMHP-C, the individual must have the designated clinical experience and must either (i) be a doctor of medicine or osteopathy licensed in Virginia; (ii) have a master's degree in psychology from an accredited college or university with at least one year of clinical experience with children and adolescents; (iii) have a social work bachelor's or master's degree from an accredited college or university with at least one year of documented clinical experience with children or adolescents; (iv) be a registered nurse with at least one year of clinical experience with children and adolescents; (v) have at least a bachelor's degree in a human services field or in special education from an accredited college with at least one year of clinical experience with children and adolescents, or (vi) be a licensed mental health professional.

"Qualified Mental Health Professional-Eligible (QMHP-E)" means a person who has: (i) at least a bachelor's degree in a human service field or special education from an accredited college without one year of clinical experience or (ii) at least a bachelor's degree in a nonrelated field and is enrolled in a master's or doctoral clinical program, taking the equivalent of at least three credit hours per semester and is employed by a provider that has a triennial license issued by the department and has a department and DMAS-approved supervision training program.

"Qualified Mental Retardation Professional (QMRP)" means a person who possesses at least one year of documented experience working directly with individuals who have mental retardation (intellectual disability) or other developmental disabilities and one of the following credentials: (i) a doctor of medicine or osteopathy licensed in Virginia, (ii) a registered nurse licensed in Virginia, or (iii) completion of at least a bachelor's degree in a human services field, including, but not limited to sociology, social work, special education, rehabilitation counseling, or psychology.

"Qualified Paraprofessional in Mental Health (QPPMH)" means a person who must, at a minimum, meet one of the following criteria: (i) registered with the United States Psychiatric Association (USPRA) as an Associate Psychiatric Rehabilitation Provider (APRP); (ii) has an associate's degree in a related field (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services counseling) and at least one year of experience providing direct services to individuals with a diagnosis of mental illness; or (iii) has a minimum of 90 hours classroom training and 12 weeks of experience under the direct personal supervision of a QMHP-Adult providing services to individuals with mental illness and at least one year of experience (including the 12 weeks of supervised experience).

"Recovery" means a journey of healing and transformation enabling an individual with a mental illness to live a meaningful life in a community of his choice while striving to achieve his full potential. For individuals with substance abuse (substance use disorders), recovery is an incremental process leading to positive social change and a full return to biological, psychological, and social functioning. For individuals with mental retardation (intellectual disability), the concept of recovery does not apply in the sense that individuals with mental retardation (intellectual disability) will need supports throughout their entire lives although these may change over time. With supports, individuals with mental retardation (intellectual disability) are capable of living lives that are fulfilling and satisfying and that bring meaning to themselves and others whom they know.

"Referral" means the process of directing an applicant or an individual to a provider or service that is designed to provide the assistance needed.

"Residential crisis stabilization service" means (i) providing short-term, intensive treatment to nonhospitalized individuals who require multidisciplinary treatment in order to stabilize acute psychiatric symptoms and prevent admission to a psychiatric inpatient unit; (ii) providing normative environments with a high assurance of safety and security for crisis intervention; and (iii) mobilizing the resources of the community support system, family members, and others for ongoing rehabilitation and recovery.

"Residential service" means providing 24-hour support in conjunction with care and treatment or a training program in a setting other than a hospital or training center. Residential services provide a range of living arrangements from highly structured and intensively supervised to relatively independent requiring a modest amount of staff support and monitoring. Residential services include residential treatment, group or community homes, supervised living, residential crisis stabilization, community gero-psychiatric residential, community intermediate care facility-MR, sponsored residential homes, medical and social detoxification, neurobehavioral services, and substance abuse residential treatment for women and children.

"Residential treatment service" means providing an intensive and highly structured mental health, substance abuse, or neurobehavioral service, or services for co-occurring disorders in a residential setting, other than an inpatient service.

"Respite care service" means providing for a short-term, time limited period of care of an individual for the purpose of providing relief to the individual's family, guardian, or regular care giver. Persons providing respite care are recruited, trained, and supervised by a licensed provider. These services may be provided in a variety of settings including residential, day support, in-home, or a sponsored residential home.

"Restraint" means the use of a mechanical device, medication, physical intervention, or hands-on hold to prevent an individual receiving services from moving his body to engage in a behavior that places him or others at imminent risk. There are three kinds of restraints:

1. Mechanical restraint means the use of a mechanical device that cannot be removed by the individual to restrict the individual's freedom of movement or functioning of a limb or portion of an individual's body when that behavior places him or others at imminent risk.

2. Pharmacological restraint means the use of a medication that is administered involuntarily for the emergency control of an individual's behavior when that individual's behavior places him or others at imminent risk and the administered medication is not a standard treatment for the individual's medical or psychiatric condition.

3. Physical restraint, also referred to as manual hold, means the use of a physical intervention or hands-on hold to prevent an individual from moving his body when that individual's behavior places him or others at imminent risk.

"Restraints for behavioral purposes" means using a physical hold, medication, or a mechanical device to control behavior or involuntary restrict the freedom of movement of an individual in an instance when all of the following conditions are met: (i) there is an emergency; (ii) nonphysical interventions are not viable; and (iii) safety issues require an immediate response.

"Restraints for medical purposes" means using a physical hold, medication, or mechanical device to limit the mobility of an individual for medical, diagnostic, or surgical purposes, such as routine dental care or radiological procedures and related post-procedure care processes, when use of the restraint is not the accepted clinical practice for treating the individual's condition.

"Restraints for protective purposes" means using a mechanical device to compensate for a physical or cognitive deficit when the individual does not have the option to remove the device. The device may limit an individual's movement, for example, bed rails or a gerichair, and prevent possible harm to the individual or it may create a passive barrier, such as a helmet to protect the individual.

"Restriction" means anything that limits or prevents an individual from freely exercising his rights and privileges.

"Screening" means the process or procedure for determining whether the individual meets the minimum criteria for admission.

"Seclusion" means the involuntary placement of an individual alone in an area secured by a door that is locked or held shut by a staff person, by physically blocking the door, or by any other physical means so that the individual cannot leave it.

"Serious injury" means any injury resulting in bodily damage, harm, or loss that requires medical attention by a licensed physician, doctor of osteopathic medicine, physician assistant, or nurse practitioner while the individual is supervised by or involved in services, such as attempted suicides, medication overdoses, or reactions from medications administered or prescribed by the service.

"Service" or "services" means (i) planned individualized interventions intended to reduce or ameliorate mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders) through care, treatment, training, habilitation, or other supports that are delivered by a provider to individuals with mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders). Services include outpatient services, intensive in-home services, opioid treatment services, inpatient psychiatric hospitalization, community gero-psychiatric residential services, assertive community treatment and other clinical services; day support, day treatment, partial hospitalization, psychosocial rehabilitation, and habilitation services; case management services; and supportive residential, halfway house, and other residential services; (ii) day support, in-home support, and crisis stabilization services provided to individuals under the IFDDS Waiver; and (iii) planned individualized interventions intended to reduce or ameliorate the effects of brain injury through care, treatment, or other supports or in residential services for persons with brain injury.

"Shall" means an obligation to act is imposed.

"Shall not" means an obligation not to act is imposed.

"Skills training" means systematic skill building through curriculum-based psychoeducational and cognitive-behavioral interventions. These interventions break down complex objectives for role performance into simpler components, including basic cognitive skills such as attention, to facilitate learning and competency.

"Social detoxification service" means providing nonmedical supervised care for the individual's natural process of withdrawal from use of alcohol or other drugs.

"Sponsored residential home" means a service where providers arrange for, supervise, and provide programmatic, financial, and service support to families or persons

(sponsors) providing care or treatment in their own homes for individuals receiving services.

"State board" means the State Board of Behavioral Health and Developmental Services. The board has statutory responsibility for adopting regulations that may be necessary to carry out the provisions of Title 37.2 of the Code of Virginia and other laws of the Commonwealth administered by the commissioner or the department.

"State methadone authority" means the Virginia Department of Behavioral Health and Developmental Services that is authorized by the federal Center for Substance Abuse Treatment to exercise the responsibility and authority for governing the treatment of opiate addiction with an opioid drug.

"Substance abuse (substance use disorders)" means the use of drugs enumerated in the Virginia Drug Control Act (§ 54.1-3400 et seq.) without a compelling medical reason or alcohol that (i) results in psychological or physiological dependence or danger to self or others as a function of continued and compulsive use or (ii) results in mental, emotional, or physical impairment that causes socially dysfunctional or socially disordering behavior; and (iii), because of such substance abuse, requires care and treatment for the health of the individual. This care and treatment may include counseling, rehabilitation, or medical or psychiatric care.

"Substance abuse intensive outpatient service" means treatment provided in a concentrated manner for two or more consecutive hours per day to groups of individuals in a nonresidential setting. This service is provided over a period of time for individuals requiring more intensive services than an outpatient service can provide. Substance abuse intensive outpatient services include multiple group therapy sessions during the week, individual and family therapy, individual monitoring, and case management.

"Substance abuse residential treatment for women with children service" means a 24-hour residential service providing an intensive and highly structured substance abuse service for women with children who live in the same facility.

"Supervised living residential service" means the provision of significant direct supervision and community support services to individuals living in apartments or other residential settings. These services differ from supportive in-home service because the provider assumes responsibility for management of the physical environment of the residence, and staff supervision and monitoring are daily and available on a 24-hour basis. Services are provided based on the needs of the individual in areas such as food preparation, housekeeping, medication administration, personal hygiene, treatment, counseling, and budgeting.

"Supportive in-home service" (formerly supportive residential) means the provision of community support services and other structured services to assist individuals, to strengthen individual skills, and that provide environmental supports necessary to attain and sustain independent community residential living. Services include drop-in or friendly-visitor support and counseling to more intensive support, monitoring, training, in-home support, respite care, and family support services. Services are based on the needs of the individual and include training and assistance. These services normally do not involve overnight care by the provider; however, due to the flexible nature of these services, overnight care may be provided on an occasional basis.

"Therapeutic day treatment for children and adolescents" means a treatment program that serves (i) children and adolescents from birth through age 17 and under certain circumstances up to 21 with serious emotional disturbances, substance use, or co-occurring disorders or (ii) children from birth through age seven who are at risk of serious emotional disturbance, in order to combine psychotherapeutic interventions with education and mental health or substance abuse treatment. Services include: evaluation; medication education and management; opportunities to learn and use daily living skills and to enhance social and interpersonal skills; and individual, group, and family counseling.

"Time out" means the involuntary removal of an individual by a staff person from a source of reinforcement to a different, open location for a specified period of time or until the problem behavior has subsided to discontinue or reduce the frequency of problematic behavior.

"Volunteer" means a person who, without financial remuneration, provides services to individuals on behalf of the provider.

VA.R. Doc. No. R19-5540; Filed December 12, 2018, 2:42 p.m.

Fast-Track Regulation

Title of Regulation: **12VAC35-210. Regulations to Govern Temporary Leave from State Mental Health and State Mental Retardation Facilities (amending 12VAC35-210-10, 12VAC35-210-20, 12VAC35-210-30, 12VAC35-210-50 through 12VAC35-210-100).**

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

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: February 6, 2019.

Effective Date: February 21, 2019.

Agency Contact: Ruth Anne Walker, Regulatory Coordinator, Department of Behavioral Health and Developmental Services, 1220 Bank Street, 11th Floor, Richmond, VA 23219, telephone (804) 225-2252, FAX (804) 786-8623, or email ruthanne.walker@dbhds.virginia.gov.

Basis: Section 37.2-203 of the Code of Virginia authorizes the State Board of Behavioral Health and Developmental Services to adopt regulations that may be necessary to carry out the provisions of Title 37.2 of the Code of Virginia and other laws of the Commonwealth administered by the commissioner and the department.

Purpose: 12VAC35-210 includes definitions, required policy, and documentation expectations related to temporary leave from mental health hospitals and training centers operated by the Department of Behavioral Health and Developmental Services. Collectively, these hospitals and training centers are referred to as "state facilities." As long as the department operates state facilities, this regulation is needed to ensure the safety of the individuals on leave.

This action is the result of a periodic review. The amendments are not substantive and merely update language to mirror language in the Code of Virginia or in 12VAC35-115, referred to as the Human Rights Regulations.

Rationale for Using Fast-Track Rulemaking Process: This action is the result of a periodic review. No comments were received during the review. The amendments merely update language to mirror current language in state law, state regulation, or practices that have been in place for many years.

Substance: There are no substantive amendments. 12VAC35-210-100 F is deleted as it is unnecessary because there is no other reference to how to "revoke" a trial visit and it is redundant with 12VAC35-210-100 D 2.

Issues: This action is the result of a periodic review, which includes a public comment period. The amendments will provide clarity for the system by providing updated language to mirror language in the Code of Virginia, 12VAC35-115, and current practice.

Small Business Impact Review Report of Findings: This fast-track regulatory action serves as the report of the findings of the regulatory review pursuant to § 2.2-4007.1 of the Code of Virginia.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. As the result of a periodic review,[1] the State Board of Behavioral Health and Developmental Services (Board) proposes to update text to mirror language in § 37.2-100 of the Code of Virginia[2] and in 12VAC35-115, Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department Of Behavioral Health and Developmental Services.[3]

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

Estimated Economic Impact. The Regulations to Govern Temporary Leave from State Mental Health and Mental Retardation Facilities are designed to: 1) inform individuals, authorized representatives, Department of Behavioral Health and Developmental Services (DBHDS) employees, community services board (CSB) staff, and pertinent stakeholders of the process and procedures related to temporary leave from state facilities, and 2) establish the conditions for granting leave, including provisions to ensure accountability and appropriate care for persons who are on leave status.

The Board's proposal to update language to mirror the Code of Virginia and 12VAC35-115 provides improved clarity and does not affect requirements in practice. Thus, the only impact of the proposed language amendments would be to better inform the public of current legal requirements and procedures. Consequently, the benefits of the proposed amendments exceed the costs.

Businesses and Entities Affected. The proposed regulation affects the 14 DBHDS facilities, 40 Virginia CSBs, and the individuals receiving services in DBHDS facilities and their families.[4]

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

Projected Impact on Employment. The proposed amendments do not affect employment.

Effects on the Use and Value of Private Property. The proposed amendments do not affect the use and value of private property.

Real Estate Development Costs. The proposed amendments do not affect real estate development costs.

Small Businesses:

Definition. Pursuant to § 2.2-4007.04 of the Code of Virginia, small business is defined as "a business entity, including its affiliates, that (i) is independently owned and operated and (ii) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million."

Costs and Other Effects. The proposed amendments do not affect costs for small businesses.

Alternative Method that Minimizes Adverse Impact. The proposed amendments do not adversely affect small businesses.

Adverse Impacts:

Businesses. The proposed amendments do not adversely affect businesses.

Localities. The proposed amendments do not adversely affect localities.

Other Entities. The proposed amendments do not adversely affect other entities.

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[1]See http://townhall.virginia.gov/L/ViewPReview.cfm?PRid=1603

[2]See https://law.lis.virginia.gov/vacode/title37.2/chapter1/section37.2-100/

[3]See https://law.lis.virginia.gov/admincode/title12/agency35/chapter115/

[4]Data Source: Department of Behavioral Health and Developmental Services

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

Summary:

The amendments (i) clarify and update the regulatory text to reflect current language in § 37.2-100 of the Code of Virginia and 12VAC35-115 and long-standing practices and (ii) include changing "family visit" to "home visit" and updating the definition of "individualized services plan."

CHAPTER 210
REGULATIONS TO GOVERN TEMPORARY LEAVE FROM STATE ~~MENTAL HEALTH AND STATE MENTAL RETARDATION~~ FACILITIES

12VAC35-210-10. ~~Authority and applicability~~ Applicability.

~~This regulation is adopted pursuant to § 37.2-837 B of the Code of Virginia to establish a process to facilitate community integration and the conditions for granting a trial or home visit to individuals admitted to state hospitals or training centers operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services.~~

This regulation shall not apply to individuals receiving services in a facility who are committed pursuant to Chapter 9 (§ 37.2-900 et seq.) of Title 37.2, Title 19.2, or Title 53.1 of the Code of Virginia.

12VAC35-210-20. Definitions.

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

"Authorized representative" or "AR" means a person permitted by law or ~~the State Mental Health, Mental Retardation, and Substance Abuse Services Board's regulations~~ regulation to authorize the disclosure of information~~;~~ or to consent to treatment and services~~,~~ or participation in human research~~; and to authorize the disclosure of information on behalf of an individual who lacks the mental capacity to make these decisions~~.

"Community services board" or "CSB" means the public body established pursuant to § 37.2-501 of the Code of Virginia that provides mental health, ~~mental retardation~~ developmental, and substance abuse services to individuals within each city or county that established it. For the purpose of ~~these regulations~~ this chapter, community services board also includes a behavioral health authority established pursuant to § 37.2-602 of the Code of Virginia.

"Day pass" means authorized leave from ~~the~~ a state facility without a staff escort generally occurring during the day and not extending overnight.

"Department" means the Department of ~~Mental~~ Behavioral Health~~, Mental Retardation~~ and ~~Substance Abuse~~ Developmental Services.

"~~Family~~" "Home visit" means an authorized overnight absence from a state hospital or training center that allows an individual to spend time with ~~family members,~~ an authorized representative~~,~~ or other responsible person ~~or persons~~.

"Individual" means a person who is receiving services in a state hospital or training center. This term includes the terms "consumer," "patient," "resident," and "client."

"Individualized services plan" or "ISP" means a comprehensive and regularly updated written plan that ~~includes but is not limited to an~~ describes the individual's needs, the measurable goals and objectives to address those needs, and strategies to reach the individual's goals. An ISP is person-centered, empowers the individual, and is designed to meet the needs and preferences of the individual. The ISP is developed through a partnership between the individual and the provider. An individual's treatment plan, ~~functional plan,~~ habilitation plan, person-centered plan, or plan of care are all considered individualized services plans ~~that meets the needs and preferences of an individual and describes the measurable goals, objectives, and expected outcomes~~.

"Missing person" means an individual who is not physically present when and where he should be and his absence cannot be accounted for or explained.

"Responsible person" means an individual's parent, spouse, legal guardian, relative, friend, or other person whom the facility director determines is capable of providing the individual with the needed care and supervision~~,~~ and, if the individual has an AR, for whom the AR has given written consent to supervise the individual during temporary leave from the state facility.

"State facility" or "facility" means a state hospital or training center operated by the department for the care and treatment of individuals with mental illness or ~~mental retardation~~ intellectual disability.

"Trial visit" means an authorized overnight absence from a state facility without a staff escort for the purpose of assessing an individual's readiness for discharge. Trial visits do not include special hospitalizations, facility-sponsored summer camps, or other facility-sponsored activities that involve staff supervision.

12VAC35-210-30. General requirements for temporary leave.

A. Directors of state facilities shall develop written operating policies and procedures for authorizing and implementing the following types of temporary leave from the facility:

1. Day passes for periods that do not extend overnight;

2. ~~Family~~ Home visits and trial visits for a maximum of 28 consecutive days per episode for individuals in training centers; and

3. ~~Family~~ Home visits and trial visits for a maximum of 14 consecutive days per episode for individuals in state hospitals.

B. The justification for all temporary leave shall be documented in the ISP. This documentation shall include:

1. The reason for granting the specific type of leave;

2. The benefit to the individual;

3. How the individual participated in the decision-making related to temporary leave; ~~and~~

4. How the leave addresses a specific ~~objective or objectives~~ outcome in the individual's ISP; and

5. The signature of the facility director or designee authorizing the temporary leave.

C. Responsible persons during leave.

1. Adults and emancipated minors receiving services in state hospitals who are granted a day pass, ~~family~~ home visit, or trial visit may be:

a. Placed in the care of a ~~parent, spouse, relative, guardian, a~~ facility licensed by the department or ~~other~~ a responsible person ~~or persons~~; or

b. Authorized to leave the facility on ~~his~~ their own recognizance, when, in the judgment of the individual and the facility director, this leave is appropriate.

2. Individuals in training centers and minors receiving services in any state hospital, who are granted a day pass, ~~family~~ home visit, or trial visit, shall be placed, with the prior written consent of the AR, in the care of~~:~~

~~a. The parent, legal guardian, or LAR AR; or~~

~~b. Another relative, friend, or other responsible person or persons, or~~ a facility licensed by the department ~~with the prior written consent of the AR~~ or a responsible person.

D. The state facility granting a trial or ~~family~~ home visit to an individual shall not be liable for ~~his~~ the individual's expenses during the period of that visit. Expenses incurred by an individual during a trial visit or ~~family~~ home visit shall be the responsibility of the person into whose care the individual is entrusted or the appropriate local department of social services of the county or city ~~of~~ in which the individual resided at the time of his admission to the facility, as appropriate, pursuant to § 37.2-837 B of the Code of Virginia.

12VAC35-210-50. Trial visits.

A. The facility and the CSB may arrange trial visits for the purpose of assessing an individual's readiness for discharge from the facility. These trial visits shall be planned during the regularly scheduled review of the ISP or at other times in collaboration with (i) the individual, (ii) the individual's family or AR, or (iii) any other person ~~or persons~~ requested by the individual. When trial visits are used in conjunction with discharge planning, the state facility treatment team shall meet with the individual to discuss ~~his~~ the individual's preferences for residential settings and give due consideration to ~~his~~ the individual's expressed preferences. If the treatment team cannot reasonably accommodate the individual's preferences, a member of the treatment team shall meet with the individual to discuss the reasons for this determination and the options that are available to ~~him~~ the individual. The treatment team shall document in the individual's record that it has met with the individual to consider ~~his~~ the individual's preferences and review the available options. All plans for trial visits shall be documented in the ISP and include consideration of the following:

1. The individual's preferences for residential setting; and

2. The individual's essential support needs ~~for support~~ and supervision requirements.

B. In advance of the trial visit, the facility shall work with the individual, CSB, and responsible persons, as appropriate, to develop an emergency contingency plan to ensure appropriate and timely crisis response.

12VAC35-210-60. ~~Family~~ Home visits.

A. ~~Family~~ Home visits may include visits with the individual's immediate or extended family, AR, friends, or other persons arranged by the family or AR.

1. Training centers shall plan ~~family~~ home visits in collaboration with the individual, ~~his~~ the individual's family or AR, and when appropriate, the CSB;

2. State hospitals shall plan ~~family~~ home visits in collaboration with the individual ~~and his~~, the individual's family or AR, and when appropriate, the CSB.

B. When planning ~~family~~ home visits, facilities shall:

1. Ensure all identified essential support needs are reviewed with the responsible person;

2. Develop plans to address potential emergencies or unexpected events;

~~2.~~ 3. Consider whether the visit has an impact on the treatment or training schedule for the individual and make appropriate accommodations; and

~~3.~~ 4. Give consideration to the individual's medical, behavioral, and psychiatric status.

12VAC35-210-70. Required authorizations and documentation.

The facility shall not release individuals for day passes, trial visits, or ~~family~~ home visits unless the required authorizations have been obtained and documentation is included in the individual's record.

12VAC35-210-80. Illness or injury occurring during a ~~family~~ day, home, or trial visit.

A. When a facility is notified that an individual is injured or ill and requires medical attention while on a day pass, trial visit, or ~~family~~ home visit, the facility director or designee shall notify the (i) facility medical director, (ii) treatment team leader, (iii) risk manager, ~~facility~~ (iv) human rights advocate, and ~~(iv)~~ (v) the CSB. The facility director shall also ensure that all events are reported in accordance with department and facility policy and protocol for risk management and any applicable law or regulation.

B. The facility director or designee may assist the CSB or the responsible person to identify an appropriate setting for the evaluation and treatment of the individual. The facility medical director may also consult with the physician and any other medical personnel who are evaluating or treating the individual. However, the individual shall not return to the facility until he is medically stabilized.

C. Individuals who have been admitted to a state hospital on a voluntary basis and require acute hospital admission for illness or injury while on temporary leave from the state hospital may voluntarily return to the state hospital following discharge from an acute care hospital if they continue to meet the admission criteria.

D. If an individual has been legally committed to a state ~~facility~~ hospital and his length of stay in an acute care hospital exceeds the period of commitment to the state ~~facility~~ hospital, the ~~facility~~ hospital shall:

1. Discharge the individual in collaboration with the CSB; and

2. Notify the individual or ~~his~~ the individual's AR in writing of the discharge.

E. If the facility is notified that an individual has died while on temporary leave, the facility director or designee shall:

1. Notify the appropriate facility and other department staff, including~~,~~ the medical director, risk manager, treatment team leader, and human rights advocate;

2. Notify the appropriate CSB and AR;

3. File the appropriate documentation of the death in accordance with department policies and procedures; and

4. Notify the state medical examiner in writing of the death in accordance with § 32.1-283 of the Code of Virginia.

12VAC35-210-90. Failure to return to training centers.

A. When an individual fails to return to a training center from any authorized day pass, ~~family~~ home visit, or trial visit within two hours of the scheduled deadline, the facility director or designee shall contact the responsible person into whose care the individual was placed to determine the cause of the delay.

B. Upon the request of the responsible person, the facility director may extend the period of a ~~family~~ home or trial visit for up to 72 hours beyond the time the individual was scheduled to return when:

1. An emergency or unforeseen circumstances delay the individual's return to the training center; and

2. The individual's AR agrees to the extension.

Extensions for emergency or unforeseen circumstances shall not be granted in advance of the ~~family~~ home visit or trial visit.

C. If an individual does not return to the training center from a day pass, trial visit, or ~~family~~ home visit within two hours of the established deadline for ~~his~~ the individual's return and the training center is unable to contact the responsible person into whose care the individual was placed, the facility director or designee may extend the period of the visit for up to 24 hours if, in his judgment, the extension is justified. During this period the facility shall continue efforts to contact the responsible person.

D. If an individual does not return to the training center and ~~his~~ the individual's absence cannot be accounted for or reasonably explained by the responsible person or a family member, ~~he~~ the individual shall be classified as a missing person, and the facility shall follow the department's policies and procedures for management of individuals who are missing.

E. If no emergency or unforeseen circumstances exist that may prevent the individual's return to the facility, and the responsible person does not agree to the return of the individual to the training center as scheduled, the facility director shall contact the CSB and discharge the individual. Written notification of discharge shall be sent to the individual's AR.

12VAC35-210-100. Failure to return to hospitals.

A. When an individual fails to return to a state hospital from any authorized day pass, ~~family~~ home visit, or trial visit within two hours of the scheduled deadline, the facility director or designee shall contact the responsible person into

whose care the individual was placed to determine the cause of the delay.

B. Upon the request of the responsible person, the facility director may extend the period of the visit for up to 72 hours beyond the time the individual was scheduled to return when:

1. An emergency or unforeseen circumstances delay the individual's return to the hospital; and

2. The individual, or ~~his~~ if applicable, the individual's AR ~~agree~~, agrees to the extension.

Extensions for emergency or unforeseen circumstances shall not be granted in advance of the ~~family~~ home visit or trial visit.

C. If an individual agrees to return to the facility, the facility director or designee may assist the individual to make arrangements for his return in collaboration with the CSB and the responsible person, when necessary.

D. If an individual is unwilling to return to the facility, the facility director or ~~his~~ facility director's designee shall contact the responsible person to determine whether continued hospitalization is appropriate or the individual should be discharged.

1. ~~If~~ Except for an individual receiving services in a state hospital who is held upon an order of a court for a criminal proceeding, if there is no evidence that the individual meets the criteria for hospitalization then the facility shall discharge the individual in collaboration with the CSB.

2. If the individual has been legally committed to the hospital and the facility director determines that the individual ~~may require further hospitalization and he~~ currently meets commitment criteria and requires further hospitalization, or ~~that~~ the individual cannot be located, the facility director shall:

a. Ensure that the commitment order is valid;

b. Classify the individual as a missing person;

c. Alert the CSB pursuant to the department's policies and procedures for ~~managing~~ management of individuals who are missing from state facilities;

d. Issue a warrant for the individual's return under § 37.2-834 of the Code of Virginia; and

e. Arrange for a physical examination at the time of the individual's return to the facility.

3. If the individual is on voluntary status or the commitment order is no longer valid, the facility director, after consulting with the appropriate clinical staff, shall:

a. Discharge the individual; and

b. Alert the CSB of the individual's status.

~~F. When it is determined that an individual who has been legally committed to the facility must be returned to the facility and the individual refuses to return on his own accord, the facility director or his designee shall:~~

~~1. Issue a warrant for the individual's return under § 37.2-834 of the Code of Virginia to the hospital; and~~

~~2. Contact the CSB upon revocation of the trial visit.~~

VA.R. Doc. No. R19-5202; Filed December 12, 2018, 2:37 p.m.

TITLE 13. HOUSING

VIRGINIA HOUSING DEVELOPMENT AUTHORITY

Final Regulation

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

Title of Regulation: **13VAC10-180. Rules and Regulations for Allocation of Low-Income Housing Tax Credits (amending 13VAC10-180-50, 13VAC10-180-60, 13VAC10-180-70, 13VAC10-180-90, 13VAC10-180-110).**

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

Effective Date: January 1, 2019.

Agency Contact: Paul M. Brennan, Chief Counsel, Virginia Housing Development Authority, 601 South Belvidere Street, Richmond, VA 23220, telephone (804) 343-5798, FAX (804) 833-8344, or email paul.brennan@vhda.com.

Summary:

The amendments:

(i) require a first leasing preference to individuals in certain identified target populations, who have rental assistance from the Commonwealth and are referred to the development by approved referring agents, and limit the tenant eligibility requirements and lease terms a developer may impose with respect to such individuals;

(ii) require all applicants to waive their rights to pursue a qualified contract and bar applicants who have participated in a qualified contract or planned foreclosure in Virginia;

(iii) add a baseline energy performance requirement and provide points for additional green building certifications;

(iv) approve the use of income averaging, subject to limitations;

(v) permit the authority to preallocate credits to developments with innovative features;

(vi) restructure the accessible supportive housing pool and require that owners have a supportive housing certification and complete the authority's supportive housing certification;

(vii) restructure the revitalization area point category, including providing points for certain deals in Opportunity Zones;

(viii) revise the cost limits for developments by creating a per square foot cost limit that is localized and remove the land and acquisition cost from such calculation but provide that a developer may meet either the current limits or new limits in 2019;

(ix) revise maximum allowable developer fees;

(x) require a general contractor cost certification;

(xi) require a physical needs assessment for rehabilitation developments;

(xii) require a Phase I environmental site assessment;

(xiii) require a site visit by authority staff as part of application review;

(xiv) provide that a prior award of credits to be refreshed in exchange for principals not being permitted to compete in the following year's competitive application process but provide a waiver if the delay is attributable to governmental delay or inaction;

(xv) limit requests for additional credits to no more than 10% of the original award of credits, otherwise the applicant must return the prior award and compete again;

(xvi) provide that owners seeking both 9.0% and 4.0% credits for a combined transaction must meet with authority staff in advance of application submission and that the two developments must be physically separate and provide points for such combined applications in the scoring of the 4.0% application;

(xvii) provide points for rent and income set-asides for units at the 30% of area median income level that are not subsidized by project-based vouchers;

(xviii) broaden the subsidized funding points category;

(xix) simplify the calculation of points for developments constructed using brick and other low-maintenance materials;

(xx) revise or provide amenity item points for multiple items, including dehumidification systems, internet service, bath vent fans, solid core interior doors, fire prevention features, USB charging ports, LED lighting, ledges at entry doors, and balconies;

(xxi) eliminate amenity item points for multiple items, including certain energy efficiency items that are duplicative in light of the new energy efficiency threshold requirements and for emergency call systems;

(xxii) reduce points awarded to developments for having real estate tax abatements;

(xxiii) give the authority the ability to remove basis boost if it determines a development is feasible without such basis boost;

(xxiv) remove penalty points for certain minor infractions;

(xxv) provide that the analyst preparing the market study must meet the authority's qualifications;

(xxvi) expand the type of project-based rental assistance or subsidy that can receive bonus points in the local housing authority pool; and

(xxvii) make other miscellaneous administrative clarifying changes.

13VAC10-180-50. Application.

Prior to submitting an application for reservation, applicants shall submit on such form as required by the executive director, the letter for authority signature by which the authority shall notify the chief executive officers (or the equivalent) of the local jurisdictions in which the developments are to be located to provide such officers a reasonable opportunity to comment on the developments.

Application for a reservation of credits shall be commenced by filing with the authority an application, on such ~~form or~~ forms as the executive director may from time to time prescribe or approve, together with such documents and additional information (including, without limitation, a market study that is prepared by a housing market analyst that meets the authority's requirements for an approved analyst, as set forth on the application form, instructions, or other communication available to the public, that shows adequate demand for the housing units to be produced by the applicant's proposed development) as may be requested by the authority in order to comply with the IRC and this chapter and to make the reservation and allocation of the credits in accordance with this chapter. The executive director may reject any application from consideration for a reservation or allocation of credits if in such application the applicant does not provide the proper documentation or information on the forms prescribed by the executive director. In addition to the market study contained in the application, the authority may conduct its own analysis of the demand for the housing units to be produced by each applicant's proposed development.

All sites in an application for a scattered site development may only serve one primary market area. If the executive director determines that the sites subject to a scattered site development are served by different primary market areas, separate applications for credits must be filed for each

primary market area in which scattered sites are located within the deadlines established by the executive director.

The application should include a breakdown of sources and uses of funds sufficiently detailed to enable the authority to ascertain what costs will be incurred and what will comprise the total financing package, including the various subsidies and the anticipated syndication or placement proceeds that will be raised. The following cost information, if applicable, needs to be included in the application to determine the feasible credit amount: site acquisition costs, site preparation costs, construction costs, construction contingency, general contractor's overhead and profit, architect and engineer's fees, permit and survey fees, insurance premiums, real estate taxes during construction, title and recording fees, construction period interest, financing fees, organizational costs, rent-up and marketing costs, accounting and auditing costs, working capital and operating deficit reserves, syndication and legal fees, development fees, and other costs and fees. All applications seeking credits for rehabilitation of existing units must provide for contractor construction costs of at least $10,000 per unit for developments financed with tax-exempt bonds and $15,000 per unit for all other developments.

Any application that exceeds the cost limits ~~set forth~~ described below ~~in subdivisions 1, 2, and 3~~ shall be rejected from further consideration hereunder and shall not be eligible for any reservation or allocation of credits. [For an application submitted in calendar year 2019 only, the higher of the following two cost limit calculations may be used by an applicant. Effective January 1, 2020, only the per square foot cost limits shall apply.]

[1. Per unit cost limits.]

[a. Inner Northern Virginia. The Inner Northern Virginia region shall consist of Arlington County, Fairfax County, City of Alexandria, City of Fairfax, and City of Falls Church. The total development cost of proposed developments in the Inner Northern Virginia region may not exceed (i) for new construction or adaptive reuse: $387,809 per unit plus up to an additional $43,090 per unit if the proposed development contains underground or structured parking for each unit or (ii) for] ~~acquisition/rehabilitation~~ [acquisition and rehabilitation: $338,564 per unit.]

~~2.~~ [b. Prince William County, Loudoun County, Fauquier County, Manassas City, and Manassas Park City. The total development cost of proposed developments in Prince William County, Loudoun County, Fauquier County, Manassas City, and Manassas Park City may not exceed (i) for new construction or adaptive reuse: $288,087 per unit plus up to an additional $43,090 per unit if the proposed development contains underground or structured parking for each unit or (ii) for] ~~acquisition/rehabilitation~~ [acquisition and rehabilitation: $203,138 per unit.]

~~3.~~ [c. Balance of the state. The total development cost of proposed developments in the balance of the state may not exceed (i) for new construction or adaptive reuse: $215,450 per unit plus up to an additional $43,090 per unit if the proposed development contains underground or structured parking for each unit or (ii) for] ~~acquisition/rehabilitation~~ [acquisition and rehabilitation: $166,204 per unit.]

[Costs, subject to a per unit limit set by the executive director, attributable to equipping units with electrical and plumbing hook-ups for dehumidification systems and attributable to installing approved dehumidification systems will not be included in the calculation of the] ~~above~~ [per unit cost limits in the preceding subdivision 1.]

[The cost limits] ~~in subdivisions 1, 2, and 3 above~~ [are 2015 fourth quarter base amounts. The cost limits shall be adjusted annually beginning in the fourth quarter of 2016 by the authority in accordance with Marshall & Swift cost factors for such quarter, and the adjusted will be indicated on the application form, instructions, or other communication available to the public.

2. Per square foot cost limits.] The authority will at least annually establish per-square-foot cost limits based upon historical cost data of tax credit developments in the Commonwealth. Such limits will be indicated on the application form, instructions, or other communication available to the public. The cost limits will be established for new construction, rehabilitation, and adaptive reuse development types. The authority will establish geographic limits utilizing Marshall & Swift cost factors. For the purpose of determining compliance with the cost limits, the value of a development's land and acquisition costs will not be included in total development cost. Compliance with [per square foot] cost limits will be determined both at the time of application and also at the time the authority issues the IRS Form 8609, with the higher of the two limits being applicable at the time of IRS Form 8609 issuance.

Each application shall include plans and specifications ~~or, in the case of rehabilitation for which plans will not be used, a unit-by-unit work write-up for such rehabilitation with certification~~ in such form and from such person satisfactory to the executive director as to the completion of such plans or specifications ~~or work write up~~.

In the case of rehabilitation, the application must include a physical needs assessment in such form and substance and prepared by such person satisfactory to the executive director pursuant to the authority's requirements as set forth on the application form, instructions, or other communication available to the public.

Each application must include an environmental site assessment (Phase I) in such form and substance and prepared by such person satisfactory to the executive director pursuant

to the authority's requirements as set forth on the application form, instructions, or other communication available to the public.

Each application shall include evidence of (i) sole fee simple ownership of the site of the proposed development by the applicant, (ii) lease of such site by the applicant for a term exceeding the compliance period (as defined in the IRC) or for such longer period as the applicant represents in the application that the development will be held for occupancy by low-income persons or families, or (iii) right to acquire or lease such site pursuant to a valid and binding written option or contract between the applicant and the fee simple owner of such site for a period extending at least four months beyond any application deadline established by the executive director, provided that such option or contract shall have no conditions within the discretion or control of such owner of such site. Any contract for the acquisition of a site with existing residential property may not require an empty building as a condition of such contract, unless relocation assistance is provided to displaced households, if any, at such level required by the authority. A contract that permits the owner to continue to market the property, even if the applicant has a right of first refusal, does not constitute the requisite site control required in clause (iii) above. No application shall be considered for a reservation or allocation of credits unless such evidence is submitted with the application and the authority determines that the applicant owns, leases, or has the right to acquire or lease the site of the proposed development as described in the preceding sentence. In the case of acquisition and rehabilitation of developments funded by Rural Development of the U.S. Department of Agriculture (Rural Development), any site control document subject to approval of the partners of the seller does not need to be approved by all partners of the seller if the general partner of the seller executing the site control document provides (i) an attorney's opinion that such general partner has the authority to enter into the site control document and such document is binding on the seller or (ii) a letter from the existing syndicator indicating a willingness to secure the necessary partner approvals upon the reservation of credits.

Each application shall include written evidence satisfactory to the authority (i) of proper zoning or special use permit for such site or (ii) that no zoning requirements or special use permits are applicable.

Each application shall include, in a form ~~or forms~~ required by the executive director, a certification of previous participation listing all developments receiving an allocation of tax credits under § 42 of the IRC in which the ~~principal or~~ principals have or had an ownership or participation interest, the location of such developments, the number of residential units and low-income housing units in such developments and such other information as more fully specified by the executive director. Furthermore, for any such development, the applicant must indicate whether the appropriate state housing credit agency has ever filed a Form 8823 with the IRS reporting noncompliance with the requirements of the IRC and that such noncompliance had not been corrected at the time of the filing of such Form 8823. The executive director may reject any application from consideration for a reservation or allocation of credits unless the above information is submitted with the application. If, after reviewing the above information or any other information available to the authority, the executive director determines that the ~~principal or~~ principals do not have the experience, financial capacity and predisposition to regulatory compliance necessary to carry out the responsibilities for the acquisition, construction, ownership, operation, marketing, maintenance and management of the proposed development or the ability to fully perform all the duties and obligations relating to the proposed development under law, regulation and the reservation and allocation documents of the authority or if an applicant is in substantial noncompliance with the requirements of the IRC, the executive director may reject applications by the applicant. No application will be accepted from any applicant with a principal that has or had an ownership or participation interest in a development at the time the authority reported such development to the IRS as no longer in compliance and is no longer participating in the federal low-income housing tax credit program.

Each application shall include, in a form ~~or forms~~ required by the executive director, a certification that the design of the proposed development meets all applicable amenity and design requirements required by the executive director for the type of housing to be provided by the proposed development.

The application should include pro forma financial statements setting forth the anticipated cash flows during the credit period as defined in the IRC. The application shall include a certification by the applicant as to the full extent of all federal, state and local subsidies that apply (or that the applicant expects to apply) with respect to each building or development. The executive director may also require the submission of a legal opinion or other assurances satisfactory to the executive director as to, among other things, compliance of the proposed development with the IRC and a certification, together with an opinion of an independent certified public accountant or other assurances satisfactory to the executive director, setting forth the calculation of the amount of credits requested by the application and certifying, among other things, that under the existing facts and circumstances the applicant will be eligible for the amount of credits requested.

Each applicant shall commit in the application to provide relocation assistance to displaced households, if any, at such level required by the executive director. Each applicant shall commit in the application to use a property management company certified by the executive director to manage the proposed development.

Unless prohibited by an applicable federal subsidy program, each applicant shall commit in the application to provide a leasing preference to individuals (i) in a target population identified in a memorandum of understanding between the authority and one or more participating agencies of the Commonwealth, (ii) having a voucher or other binding commitment for rental assistance from the Commonwealth, and (iii) referred to the development by a referring agent approved by the authority. The leasing preference shall not be applied to more than 10% of the units in the development at any given time. The applicant may not impose [~~more restrictive~~] tenant selection criteria or leasing terms with respect to individuals receiving this preference [that are more restrictive than the applicant's tenant selection criteria or leasing terms applicable to prospective tenants in the development that do not receive this preference, the eligibility criteria for the rental assistance from the Commonwealth, or any eligibility criteria contained in a memorandum of understanding between the authority and one or more participating agencies of the Commonwealth].

Each applicant shall commit in the application not to require an annual minimum income requirement that exceeds the greater of $3,600 or 2.5 times the portion of rent to be paid by tenants receiving rental assistance.

Each applicant shall commit in the application to waive its right to request to terminate the extended low-income housing commitment through the qualified contract process, as described in the IRC. Further, any application submitted by an applicant containing a principal that was a principal in an owner that has previously requested, on or after January 1, 2019, a qualified contract in the Commonwealth (regardless of whether the extended low-income housing commitment was terminated through such process) shall be rejected from further consideration and shall not be eligible for any reservation or allocation of credits.

Any application submitted by an applicant containing a principal that was a principal in an owner that has, in the authority's determination, previously participated, on or after January 1, 2019, in a foreclosure in Virginia (or instrument in lieu of foreclosure) that was part of an arrangement a purpose of which was to terminate an extended low-income housing commitment (regardless whether the extended low-income housing commitment was terminated through such foreclosure or instrument) shall be rejected from further consideration and shall not be eligible for any reservation or allocation of credits.

If an applicant submits an application for reservation or allocation of credits that contains a material misrepresentation or fails to include information regarding developments involving the applicant that have been determined to be out of compliance with the requirements of the IRC, the executive director may reject the application or stop processing such application upon discovery of such misrepresentation or noncompliance and may prohibit such applicant from submitting applications for credits to the authority in the future.

In any situation in which the executive director deems it appropriate, he may treat two or more applications as a single application. Only one application may be submitted for each location.

The executive director may establish criteria and assumptions to be used by the applicant in the calculation of amounts in the application, and any such criteria and assumptions may be indicated on the application form, instructions or other communication available to the public.

The executive director may prescribe such deadlines for submission of applications for reservation and allocation of credits for any calendar year as he shall deem necessary or desirable to allow sufficient processing time for the authority to make such reservations and allocations. If the executive director determines that an applicant for a reservation of credits has failed to submit one or more mandatory attachments to the application by the reservation application deadline, he may allow such applicant an opportunity to submit such attachments within a certain time established by the executive director with a 10-point scoring penalty per item.

After receipt of the applications local notification information data, if necessary, the authority shall notify the chief executive officers (or the equivalent) of the local jurisdictions in which the developments are to be located and shall provide such officers a reasonable opportunity to comment on the developments.

The development for which an application is submitted may be, but shall not be required to be, financed by the authority. If any such development is to be financed by the authority, the application for such financing shall be submitted to and received by the authority in accordance with its applicable rules and regulations.

The authority may consider and approve, in accordance herewith, both the reservation and the allocation of credits to buildings or developments that the authority may own or may intend to acquire, construct ~~and/or~~ or rehabilitate.

Any application seeking an additional reservation of credits for a development in excess of 10% of an existing reservation of credits for such development shall be rejected from further consideration hereunder and shall not be eligible for any reservation or allocation of credits pursuant to such application. However, such applicant may execute a consent to cancellation for such existing reservation and submit a new application for the aggregate amount of the existing reservation and any desired increase.

13VAC10-180-60. Review and selection of applications; reservation of credits.

The executive director may divide the amount of credits into separate pools and each separate pool may be further divided into separate tiers. The division of such pools and tiers may be based upon one or more of the following factors: geographical areas of the state; types or characteristics of housing, construction, financing, owners, occupants, or source of credits; or any other factors deemed appropriate by him to best meet the housing needs of the Commonwealth.

An amount, as determined by the executive director, not less than 10% of the Commonwealth's annual state housing credit ceiling for credits, shall be available for reservation and allocation to buildings or developments with respect to which the following requirements are met:

1. A "qualified nonprofit organization" (as described in § 42(h)(5)(C) of the IRC) that is authorized to do business in Virginia and is determined by the executive director, on the basis of such relevant factors as he shall consider appropriate, to be substantially based or active in the community of the development and is to materially participate (regular, continuous and substantial involvement as determined by the executive director) in the development and operation of the development throughout the "compliance period" (as defined in § 42(i)(1) of the IRC); and

2. (i) The "qualified nonprofit organization" described in the preceding subdivision 1 is to own (directly or through a partnership), prior to the reservation of credits to the buildings or development, all of the general partnership interests of the ownership entity thereof; (ii) the executive director of the authority shall have determined that such qualified nonprofit organization is not affiliated with or controlled by a for-profit organization; (iii) the executive director of the authority shall have determined that the qualified nonprofit organization was not formed by one or more individuals or for-profit entities for the principal purpose of being included in any nonprofit pools (as defined below) established by the executive director, and (iv) the executive director of the authority shall have determined that no staff member, officer or member of the board of directors of such qualified nonprofit organization will materially participate, directly or indirectly, in the proposed development as a for-profit entity.

In making the determinations required by the preceding subdivision 1 and clauses (ii), (iii) and (iv) of this subdivision 2 ~~of this section~~, the executive director may apply such factors as he deems relevant, including~~, without limitation,~~ the past experience and anticipated future activities of the qualified nonprofit organization, the sources and manner of funding of the qualified nonprofit organization, the date of formation and expected life of the qualified nonprofit organization, the number of paid staff members and volunteers of the qualified nonprofit organization, the nature and extent of the qualified nonprofit organization's proposed involvement in the construction or rehabilitation and the operation of the proposed development, the relationship of the staff, directors or other principals involved in the formation or operation of the qualified nonprofit organization with any persons or entities to be involved in the proposed development on a for-profit basis, and the proposed involvement in the construction or rehabilitation and operation of the proposed development by any persons or entities involved in the proposed development on a for-profit basis. The executive director may include in the application of the foregoing factors any other nonprofit organizations that, in his determination, are related (by shared directors, staff or otherwise) to the qualified nonprofit organization for which such determination is to be made.

For purposes of the foregoing requirements, a qualified nonprofit organization shall be treated as satisfying such requirements if any qualified corporation (as defined in § 42(h)(5)(D)(ii) of the IRC) in which such organization (by itself or in combination with one or more qualified nonprofit organizations) holds 100% of the stock satisfies such requirements.

The applications shall include such representations and warranties and such information as the executive director may require in order to determine that the foregoing requirements have been satisfied. In no event shall more than 90% of the Commonwealth's annual state housing credit ceiling for credits be available for developments other than those satisfying the preceding requirements. The executive director may establish such pools (nonprofit pools) of credits as he may deem appropriate to satisfy the foregoing requirement. If any such nonprofit pools are so established, the executive director may rank the applications therein and reserve credits to such applications before ranking applications and reserving credits in other pools, and any such applications in such nonprofit pools not receiving any reservations of credits or receiving such reservations in amounts less than the full amount permissible hereunder (because there are not enough credits then available in such nonprofit pools to make such reservations) shall be assigned to such other pool as shall be appropriate hereunder; provided, however, that if credits are later made available (pursuant to the IRC or as a result of either a termination or reduction of a reservation of credits made from any nonprofit pools or a rescission in whole or in part of an allocation of credits made from such nonprofit pools or otherwise) for reservation and allocation by the authority during the same calendar year as that in which applications in the nonprofit pools have been so assigned to other pools as described above, the executive director may, in such situations, designate all or any portion of such additional credits for the nonprofit pools (or for any other pools as he

shall determine) and may, if additional credits have been so designated for the nonprofit pools, reassign such applications to such nonprofit pools, rank the applications therein and reserve credits to such applications in accordance with the IRC and this chapter. In the event that during any round (as authorized hereinbelow) of application review and ranking the amount of credits reserved within such nonprofit pools is less than the total amount of credits made available therein, the executive director may either (i) leave such unreserved credits in such nonprofit pools for reservation and allocation in any subsequent round ~~or rounds~~ or (ii) redistribute, to the extent permissible under the IRC, such unreserved credits to such other ~~pool or~~ pools as the executive director shall designate reservations therefore in the full amount permissible hereunder (which applications shall hereinafter be referred to as "excess qualified applications") or (iii) carry over such unreserved credits to the next succeeding calendar year for the inclusion in the state housing credit ceiling (as defined in § 42(h)(3)(C) of the IRC) for such year. Notwithstanding anything to the contrary herein, no reservation of credits shall be made from any nonprofit pools to any application with respect to which the qualified nonprofit organization has not yet been legally formed in accordance with the requirements of the IRC. In addition, no application for credits from any nonprofit pools or any combination of pools may receive a reservation or allocation of annual credits in an amount greater than $950,000 unless credits remain available in such nonprofit pools after all eligible applications for credits from such nonprofit pools receive a reservation of credits.

Notwithstanding anything to the contrary herein, applicants relying on the experience of a local housing authority for developer experience points described hereinbelow ~~and/or~~ or using Hope VI funds from HUD in connection with the proposed development shall not be eligible to receive a reservation of credits from any nonprofit pools.

The authority shall review each application, and, based on the application and other information available to the authority, shall assign points to each application as follows:

1. Readiness. ~~a.~~ Written evidence satisfactory to the authority of unconditional approval by local authorities of the plan of development or site plan for the proposed development or that such approval is not required. (40 points; applicants receiving points under this subdivision 1 ~~a~~ are not eligible for points under subdivision 5 a below)

~~b. For applications submitted prior to January 1, 2016, written evidence satisfactory to the authority (i) of proper zoning or special use permit for such site or (ii) that no zoning requirements or special use permits are applicable. (40 points)~~

2. Housing needs characteristics.

a. Submission of the form prescribed by the authority with any required attachments, providing such information necessary for the authority to send a letter addressed to the current chief executive officer (or the equivalent) of the locality in which the proposed development is located, soliciting input on the proposed development from the locality within the deadlines established by the executive director. (minus 50 points for failure to make timely submission)

b. A letter in response to its notification to the chief executive officer of the locality in which the proposed development is to be located opposing the allocation of credits to the applicant for the development. In any such letter, the chief executive officer must certify that the proposed development is not consistent with current zoning or other applicable land use regulations. Any such letter must also be accompanied by a legal opinion of the locality's attorney opining that the locality's opposition to the proposed development does not have a discriminatory intent or a discriminatory effect (as defined in 24 CFR 100.500(a)) that is not supported by a legally sufficient justification (as defined in 24 CFR 100.500(b)) in violation of the Fair Housing Act (Title VIII of the Civil Rights Act of 1968, as amended) and the HUD implementing regulations. (minus 25 points)

c. Any proposed development that is to be located in a revitalization area meeting the requirements of § 36-55.30:2 A of the Code of Virginia~~. (10 points)~~ or within an opportunity zone designated by the Commonwealth pursuant to the Federal Tax Cuts and Jobs Act of 2017, as follows: (i) in a qualified census tract or federal targeted area, both as defined in the IRC, deemed under § 36-55.30:2 of the Code of Virginia to be designated as a revitalization area without adoption of a resolution (10 points); (ii) in any redevelopment area, conservation area, or rehabilitation area created or designated by the city or county pursuant to Chapter 1 (§ 36-1 et seq.) of Title 36 of the Code of Virginia and deemed under § 36-55.30:2 to be designated as a revitalization area without adoption of a further resolution (10 points); (iii) in a revitalization area designated by resolution adopted pursuant to the terms of § 36-55.30:2 (15 points); (iv) in a local housing rehabilitation zone created by an ordinance passed by the city, county, or town and deemed to meet the requirements of § 36-55.30:2 pursuant to § 36-55.64 G of the Code of Virginia (15 points); and (v) in an opportunity zone and having a binding commitment of funding acceptable to the executive director pursuant to requirements as set forth on the application form, instructions, or other communication available to the public. [~~(20~~ (15] points). If the development is located in more than one such area, only the highest applicable points will be

awarded, that is, points in this subdivision c are not cumulative.

d. Commitment by the applicant for any development without section 8 project-based assistance to give leasing preference to individuals and families (i) on public housing waiting lists maintained by the local housing authority operating in the locality in which the proposed development is to be located and notification of the availability of such units to the local housing authority by the applicant or (ii) on section 8 (as defined in 13VAC10-180-90) waiting lists maintained by the local or nearest section 8 administrator for the locality in which the proposed development is to be located and notification of the availability of such units to the local section 8 administrator by the applicant. (5 points)

e. ~~Any of the following: (i) firm financing commitment(s) from the local government, local housing authority, Federal Home Loan Bank affordable housing funds, Virginia Housing Trust Fund, funding from VOICE for projects located in Prince William County and donations from unrelated private foundations that have filed an IRS Form 990 (or a variation of such form) or Rural Development for a below market rate loan or grant; (ii) a resolution passed by the locality in which the proposed development is to be located committing such financial support to the development in a form approved by the authority; (iii) a commitment to donate land, buildings or tap fee waivers from the local government; or (iv) a commitment to donate land (including a below market rate land lease) from an entity that is not a principal in the applicant (the donor being the grantee of a right of first refusal or purchase option, with no ownership interest in the applicant, shall not make the donor a principal in the applicant).~~ Any [~~nonfederal~~ (i)] funding source, as evidenced by a binding commitment or letter of intent, that is used to reduce the credit request [; (ii) commitment to donate land or buildings or tap fee waivers from the local government; or (iii) commitment to donate land (including a below market-rate land lease) from an entity that is not a principal in the applicant (the donor being the grantee of a right of first refusal or purchase option with no ownership interest in the applicant shall not make the donor a principal in the applicant)]. Loans must be below market-rate (the one-year London Interbank Offered Rate (LIBOR) rate at the time of commitment) or cash-flow only to be eligible for points. Financing from the authority and market rate permanent financing sources are not eligible. [~~Funding from the Federal Home Loan Bank is eligible.~~] (The amount of such ~~financing~~ funding, dollar value of local support, or value of donated land (including a below market rate land lease) will be determined by the executive director and divided by the total development ~~sources of funds and the proposed development~~ cost. The applicant receives two points for each percentage point up to a maximum of 40 points.) [The authority will confirm receipt of such subsidized funding prior to the issuance of IRS Form 8609.]

f. Any development subject to (i) HUD's Section 8 or Section 236 program or (ii) Rural Development's 515 program, at the time of application. (20 points, unless the applicant is or has any common interests with the current owner, directly or indirectly, the application will only qualify for these points if the applicant waives all rights to ~~any~~ developer's fee on acquisition and any other fees associated with the acquisition ~~and rehabilitation (or rehabilitation only)~~ of the development unless permitted by the executive director for good cause.)

g. Any development receiving ~~(i)~~ a real estate tax abatement on the increase in the value of the development ~~or (ii) new project-based subsidy from HUD or Rural Development for the greater of five units or 10% of the units of the proposed development~~. ~~(10~~ (5 points)

~~h. Any proposed elderly development located in a census tract that has less than a 10% poverty rate (based upon Census Bureau data) (25 points). Effective January 1, 2018, any proposed elderly development located in a census tract that has less than a 12% poverty rate (based upon Census Bureau data) (20 points); any proposed elderly development located in a census tract that has less than a 3.0% poverty rate (based upon Census Bureau data) (30 points).~~

~~i. Any proposed family development located in a census tract that has less than a 10% poverty rate (based upon Census Bureau data) (25 points). Effective January 1, 2018, any proposed family development located in a census tract that has less than a 12% poverty rate (based upon Census Bureau data) (20 points); any proposed family development located in a census tract that has less than a 3.0% poverty rate (based upon Census Bureau data) (30 points).~~

h. Any development receiving new project-based subsidy from HUD or Rural Development for the greater of five units or 10% of the units of the proposed development. (10 points)

i. Any proposed elderly or family development located in a census tract that has less than a 3.0% poverty rate based upon Census Bureau data (30 points); less than a 10% poverty rate based upon Census Bureau data (25 points); or less than a 12% poverty rate based upon Census Bureau data. (20 points)

j. Any proposed development listed in the top 25 developments identified by Rural Development as high priority for rehabilitation at the time the application is submitted to the authority (15 points).

k. Any proposed new construction development (including adaptive reuse and rehabilitation that creates additional rental space) located in a pool identified by the authority as a pool with little or no increase in rent-burdened population. ~~(up~~ (Up to minus 20 points, depending upon the portion of the development that is additional rental space, in all pools except the at-large pool, 0 points in the at-large pool; the executive director may make exceptions in the following circumstances:

(1) Specialized types of housing designed to meet special needs that cannot readily be addressed utilizing existing residential structures;

(2) Housing designed to serve as a replacement for housing being demolished through redevelopment; or

(3) Housing that is an integral part of a neighborhood revitalization project sponsored by a local housing authority.)

l. Any proposed new construction development (including adaptive reuse and rehabilitation that creates additional rental space) that is located in a pool identified by the authority as a pool with an increasing rent-burdened population. ~~(up~~ (Up to 20 points, depending upon the portion of the development that is additional rental space, in all pools except the at-large pool, 0 points in the at-large pool).

3. Development characteristics.

a. Evidence satisfactory to the authority documenting the quality of the proposed development's amenities as determined by the following:

(1) The following points are available for any application:

(a) If a ~~community/meeting~~ community room with a minimum of 749 square feet is provided. (5 points) Community rooms receiving points under this subdivision 3 a (1) (a) may not be used for commercial purposes. ~~Effective January 1, 2018, provided~~ Provided that the cost of the community room is not included in eligible basis, the owner may conduct, or contract with a nonprofit provider to conduct, programs or classes for tenants and members of the community in the community room, so long as (i) tenants compose at least one-third of participants, with first preference given to tenants above the one-third minimum; (ii) no program or class may be offered more than five days per week; (iii) no individual program or class may last more than eight hours per day, and all programs and class sessions may not last more than 10 hours per day in the aggregate; (iv) cost of attendance of the program or class must be below market rate with no profit from the operation of the class or program being generated for the owner (owner may also collect an amount ~~of~~ for reimbursement of supplies and clean-up costs); (v) the community room must be available for use by tenants when programs and classes are not offered, subject to reasonable "quiet hours" established by owner; and (vi) any owner offering programs or classes must provide an annual certification to the authority that it is in compliance with such requirements, with failure to comply with these requirements resulting in a 10-point penalty for three years from the date of such noncompliance for principals in the owner.

(b) If the exterior walls are constructed using ~~the following materials: (i) Brick~~ brick or other similar low-maintenance material approved by the authority (as indicated on the application form, instructions, or other communication available to the public) covering ~~30% or more of the exterior walls~~ 25% or greater, up to and including 85%, of the exterior walls of the development. For purposes of making such coverage calculation, the triangular gable end area, doors, windows, knee walls, columns, retaining walls, and any features that are not a part of the façade are excluded from the denominator. Community buildings are included in the foregoing coverage calculations. (Zero points if coverage is less than 25%; 10 points if coverage is at least 25%, and an additional 15 points is available on a sliding scale if coverage is greater than 25% up to and including 85% coverage. No additional points if coverage is greater than 85%). ~~(10 points) and~~

~~(ii) If subdivision 3 a (1) (b) (i) above is met, an additional one-fifth point for each percent of exterior wall brick or other similar low-maintenance material approved by the authority (as indicated on the application form, instructions, or other communication available to the public) in excess of 30%. (maximum 10 points) and~~

~~(iii) If subdivision 3 a (1) (b) (i) above is met, an additional one-tenth point for each percent of exterior wall covered by fiber-cement board. (maximum 7 points)~~

~~(c) If all kitchen and laundry appliances (except range hoods) meet the EPA's Energy Star qualified program requirements. (5 points)~~

~~(d) If all the windows and glass doors are Energy Star labeled for the North-Central Zone or are National Fenestration Rating Council (NFRC) labeled with a maximum U-Factor of 0.27 and maximum solar heat gain coefficient (SHGC) of 0.40. (5 points)~~

~~(e) If every unit in the development is heated and cooled with either (i) heat pump equipment with both a seasonal energy efficiency ratio (SEER) rating of 15.0 or more and a heating seasonal performance factor (HSPF) rating of 8.5 or more or (ii) air conditioning equipment with a SEER rating of 15.0 or more, combined with a gas~~

~~furnace with an annual fuel utilization efficiency (AFUE) rating of 90% or more. (10 points)~~

~~(f)~~ (c) If the water expense is submetered (the tenant will pay monthly or bimonthly bill). (5 points)

~~(g)~~ (d) If points are not awarded pursuant to subdivision 3 f [~~below~~ of this section] for optional certification, if each bathroom contains only WaterSense labeled toilets, faucets and showerheads. ~~(2~~ (3 points)

~~(h)~~ (e) If each unit is provided with the necessary infrastructure for high-speed Internet or broadband service. (1 point)

~~(i) If all the water heaters have an energy factor greater than or equal to 67% for gas water heaters or greater than or equal to 93% for electric water heaters; or any centralized commercial system that has an efficiency performance rating equal to or greater than 95%, or any solar thermal system that meets at least 60% of the development's domestic hot water load~~ If free Wi-Fi access is provided in the community room and such access is restricted to resident only usage. (4 points) If each unit is provided with free individual high-speed Internet access. (6 points, 8 points if such access is Wi-Fi). ~~(5 points)~~

~~(j) If each bathroom is equipped with a WaterSense labeled toilet. (2 points)~~

~~(k) Effective until January 1, 2018, for new construction only, if each full bathroom is equipped with EPA Energy Star qualified bath vent fans. (2 points) Effective January 1, 2018, if each full bathroom is provided either an EPA Energy Star qualified bath vent fan with duct size per manufacturer requirements or a continuous exhaust as part of a dedicated outdoor air system with humidity control. (2 points)~~

~~(l) If the development has or the application provides for installation of continuous R-3 or higher wall sheathing insulation. (5 points)~~

~~(m)~~ (f) If each full bathroom's bath fans are wired to the primary bathroom light with a delayed timer, or continuous exhaust by ERV/DOAS. (3 points) If each full bathroom's bath fans are equipped with a humidistat. (3 points)

(g) If all cooking surfaces are equipped with fire prevention features that meet the authority's requirements as indicated on the application form, instructions, or other communication available to the public. (4 points)

If all cooking surfaces are equipped with fire ~~prevention or~~ suppression features that meet the authority's requirements (as indicated on the application form, instructions, or other communication available to the public). (2 points)

(h) For rehabilitations, equipping all units with dedicated space, drain, and electrical hook-ups for permanently installed dehumidification systems (2 points). For rehabilitations and new construction, providing permanently installed dehumidification systems in each unit. (5 points)

(i) If each interior door is solid core. (3 points)

(j) If each unit has at least one USB charging port in the kitchen, living room, and all bedrooms. (1 point)

(k) If each kitchen has LED lighting in all fixtures that meets the authority's minimum design and construction standards (2 points)

(l) If each unit has a shelf or ledge outside the primary entry door in interior hallway. (2 points)

(m) For new construction only, if each unit has a balcony or patio with a minimum depth of five feet clear from face of building and a size of at least 30 square feet. (4 points)

(2) The following points are available to applications electing to serve elderly tenants:

(a) If all cooking ranges have front controls. (1 point)

(b) If all ~~units have an emergency call system. (3 points) (c) If all~~ bathrooms have an independent or supplemental heat source. (1 point)

~~(d)~~ (c) If all entrance doors to each unit have two eye viewers, one at 42 inches and the other at standard height. (1 point)

(3) If the structure is historic, by virtue of being listed individually in the National Register of Historic Places, or due to its location in a registered historic district and certified by the Secretary of the Interior as being of historical significance to the district, and the rehabilitation will be completed in such a manner as to be eligible for historic rehabilitation tax credits. (5 points)

b. Any development in which (i) the greater of five units or 10% of the units will be assisted by HUD project-based vouchers (as evidenced by the submission of a letter satisfactory to the authority from an authorized public housing authority (PHA) that the development meets all prerequisites for such assistance) or other form of documented and binding federal or state project-based rent subsidies in order to ensure occupancy by extremely low-income persons; and (ii) the greater of five units or 10% of the units will conform to HUD regulations interpreting the accessibility requirements of § 504 of the Rehabilitation Act and be actively marketed to persons with disabilities as defined in the Fair Housing Act in accordance with a plan submitted as part of the application for credits (all common space must also conform to HUD regulations interpreting the accessibility

requirements of § 504 of the Rehabilitation Act, and all the units described in clause (ii) above must include roll-in showers and roll-under sinks and front control ranges, unless agreed to by the authority prior to the applicant's submission of its application). (60 points)

~~In addition, for any development eligible for the preceding 60 points, subject to appropriate federal approval, any applicant that commits to providing a first preference on its waiting list for persons with a developmental disability as confirmed by the Virginia Department of Behavioral Health and Developmental Services for the greater of five units or 10% of the units. (25 points)~~

c. Any development in which the greater of five units or 10% of the units (i) have rents within HUD's Housing Choice Voucher (HCV) payment standard, (ii) conform to HUD regulations interpreting the accessibility requirements of § 504 of the Rehabilitation Act, and (iii) are actively marketed to persons with disabilities as defined in the Fair Housing Act in accordance with a plan submitted as part of the application for credits (all common space must also conform to HUD regulations interpreting the accessibility requirements of § 504 of the Rehabilitation Act). (30 points)

~~In addition, for any development eligible for the preceding 30 points, subject to appropriate federal approval, any applicant that commits to providing a first preference on its waiting list for persons with a developmental disability as confirmed by the Virginia Department of Behavioral Health and Developmental Services for the greater of five units or 10% of the units. (25 points)~~

d. Any development in which 5.0% of the units (i) conform to HUD regulations interpreting the accessibility requirements of § 504 of the Rehabilitation Act and (ii) are actively marketed to persons with disabilities as defined in the Fair Housing Act in accordance with a plan submitted as part of the application for credits. (15 points)

e. Any development located within one-half mile of an existing commuter rail, light rail or subway station or one-quarter mile of one or more existing public bus stops. (10 points, unless the development is located within the geographical area established by the executive director for a pool of credits for Northern Virginia or Tidewater Metropolitan Statistical Area (MSA), in which case, the development will receive 20 points if the development is ranked against other developments in such Northern Virginia or Tidewater MSA pool, 10 points if the development is ranked against other developments in any other pool of credits established by the executive director)

f. Each development must meet the following baseline energy performance standard applicable to the development's construction category. For new construction, the development must meet all requirements for EPA Energy Star certification. For rehabilitation, the proposed renovation of the development must result in at least a 30% post-rehabilitation [~~increase~~ decrease] on the Home Energy Rating System Index (HERS Index) or score an 80 or [~~better~~ lower] on the HERS Index. For adaptive reuse, the proposed development must score a 95 or [~~better~~ lower] on the HERS Index. For mixed construction types, the applicable standard will apply to the development's various construction categories. The development's score on the HERS Index must be verified by a third-party, independent, nonaffiliated, certified Residential Energy Services Network (RESNET) home energy rater.

Any development for which the applicant agrees to obtain ~~either~~ (i) EarthCraft Gold or higher certification ~~or;~~ (ii) U.S. Green Building Council LEED green-building certification; (iii) National Green Building Standard Certification of Silver or higher; or (iv) meet Enterprise Green Communities Criteria prior to the issuance of an IRS Form 8609 with the proposed development's architect certifying in the application that the development's design will meet the criteria for such certification, provided that the proposed development's ~~architect is on the authority's list of LEED/EarthCraft certified architects. (15 points for a LEED Silver development or EarthCraft certified development; 35 points for a LEED Gold development or EarthCraft Gold development; 45 points for a LEED Platinum development and an additional 10 points for an EarthCraft certified development or EarthCraft Gold development that performs tenant utility monitoring and benchmarking.)~~ RESNET rater is registered with a provider on the authority's approved RESNET provider list. (10 points, points in this paragraph are not cumulative)

Additionally, points on future applications will be awarded to an applicant having a principal that is also a principal in a tax credit development in the Commonwealth meeting (i) the Zero Energy Ready Home Requirements as promulgated by the U.S. Department of Energy (DOE) and as evidenced by a DOE certificate; or (ii) the Passive House Institute's Passive House standards as evidenced by a certificate from an accredited Passive House certifier. (10 points, points in this paragraph are cumulative)

The executive director may, if needed, designate a proposed development as requiring an increase in credit in order to be financially feasible and such development shall be treated as if in a difficult development area as

provided in the IRC for any applicant receiving ~~25 or 45~~ an additional 10 points under this subdivision, provided however, any resulting increase in such development's eligible basis shall be limited to ~~5.0%~~ 10% of the development's eligible basis ~~for 25 points awarded under this subdivision and 10% for 45 points awarded under this subdivision of~~. Provided, however, the authority may remove such increase in the development's eligible basis if the authority determines that the development is financially feasible without such increase in basis.

g. If units are constructed to include the authority's universal design features, provided that the proposed development's architect is on the authority's list of universal design certified architects. (15 points, if all the units in an elderly development meet this requirement; 15 points multiplied by the percentage of units meeting this requirement for nonelderly developments)

[h. Any development in which the applicant proposes to produce less than 100 low-income housing units. (20 points for producing 50 low-income housing units or less, minus 0.4 points for each additional low-income housing unit produced down to 0 points for any development that produces 100 or more low-income housing units.)

i. ~~h.~~] Any applicant for a development that, pursuant to a common plan of development, is part of a larger development located on the same or contiguous sites, financed in part by tax-exempt bonds. Combination developments seeking both 9.0% and 4.0% credits must clearly be presented as two separately financed deals including separate equity pricing that would support each respective deal in the event the other were no longer present. While deals are required to be on the same or a contiguous site they must be clearly identifiable as separate. The units financed by tax exempt bonds may not be interspersed throughout the development. Additionally, if co-located within the same building footprint, the property must identify separate entrances. All applicants seeking points in this category must arrange a meeting with authority staff at the authority's offices prior to the deadline for submission of the application in order to review both the 9.0% and the tax-exempt bond financed portion of the project. Any applicant failing to meet with authority staff in advance of applying will not be allowed to compete in the current competitive round as a combination development. (25 points for tax-exempt bond financing of at least 30% of aggregate units, 35 points for tax-exempt bond financing of at least 40% of aggregate units, and 45 points for tax-exempt bond financing of at least 50% of aggregate units; such points being ~~noncumulative)~~ noncumulative; such points will be awarded in both the application and any application submitted for credits associated with the tax-exempt bonds)

4. Tenant population characteristics. Commitment by the applicant to give a leasing preference to individuals and families with children in developments that will have no more than 20% of its units with one bedroom or less. (15 points; plus 0.75 points for each percent of the low-income units in the development with three or more bedrooms up to an additional 15 points for a total of no more than 30 points)

5. Sponsor characteristics.

a. Evidence that the controlling general partner or managing member of the controlling general partner or managing member for the proposed development have developed:

(1) As controlling general partner or managing member, (i) at least three tax credit developments that contain at least three times the number of housing units in the proposed development or (ii) at least six tax credit developments. (50 points) ~~or~~;

(2) At least three deals as a principal and have at least $500,000 in liquid assets. "Liquid assets" means cash, cash equivalents, and investments held in the name of the ~~entity(s) and~~ entities or ~~person(s)~~ persons, including cash in bank accounts, money market funds, U.S. Treasury bills, and equities traded on the New York Stock Exchange or NASDAQ. Certain cash and investments will not be considered liquid assets, including ~~but not limited to~~: (i) stock held in the applicant's own company or any closely held entity, (ii) investments in retirement accounts, (iii) cash or investments pledged as collateral for any liability, and (iv) cash in property accounts, including reserves. The authority will assess the financial capacity of the applicant based on its financial statements. The authority will accept financial statements audited, reviewed, or compiled by an independent certified public accountant. Only a balance sheet dated on or after December 31 of the year prior to the application deadline is required. The authority will accept a compilation report with or without full note disclosures. Supplementary schedules for all significant assets and liabilities may be required. Financial statements prepared in accordance with accounting principles generally accepted in the United States (U.S. GAAP) are preferred. Statements prepared in the income tax basis or cash basis must disclose that basis in the report. The authority reserves the right to verify information in the financial statements. (50 points)~~;~~ or

(3) As controlling general partner or managing member, at least one tax credit development that contains at least the number of housing units in the proposed development. (10 points)

Applicants receiving points under subdivisions a (1) and a (2) of this subdivision 5 shall have the 50 points

reduced if the controlling general partner or managing member of the controlling general partner or managing member in the applicant acted as a principal in a development receiving an allocation of credits from the authority where:

(a) ~~such~~ Such principal met the requirements to be eligible for points under 5 (a) (1) or (2) and

(b) ~~any of the following occurred: (i) submission of a Form 8609 application that failed to match the required accountant's cost certification (minus 10 points for~~ [~~For two~~] ~~years); (ii) failure to place a rehabilitation development in service by substantial completion (e.g., placed in service by expenditures after two years) (minus 5 points for two years); (iii)~~ [~~years~~ Such principal] made more than two requests for final inspection (minus 5 points for two years)~~; or (iv) requests for any deadline extension (minus 1 point for two years)~~.

Applicants receiving points under subdivisions a (1) and a (2) of this subdivision 5 are not eligible for points under ~~subdivision a of~~ subdivision 1 ~~Readiness,~~ above.

b. Any applicant that includes a principal that was a principal in a development at the time the authority inspected such development and discovered a life-threatening hazard under HUD's Uniform Physical Condition Standards and such hazard was not corrected in the timeframe established by the authority. (minus 50 points for a period of three years after the violation has been corrected)

c. Any applicant that includes a principal that was a principal in a development that either (i) at the time the authority reported such development to the IRS for noncompliance had not corrected such noncompliance by the time a Form 8823 was filed by the authority or (ii) remained out-of-compliance with the terms of its extended use commitment after notice and expiration of any cure period set by the authority. (minus 15 points for a period of three calendar years after the year the authority filed Form 8823 or expiration of such cure period, unless the executive director determines that such principal's attempts to correct such noncompliance was prohibited by a court, local government or governmental agency, in which case, no negative points will be assessed to the applicant, or 0 points, if the appropriate ~~individual or~~ individuals connected to the principal attend compliance training as recommended by the authority)

d. Any applicant that includes a principal that is or was a principal in a development that (i) did not build a development as represented in the application for credit (minus two times the number of points assigned to the ~~item or~~ items not built or minus 20 points for failing to provide a minimum building requirement, for a period of three years after the last Form 8609 is issued for the development, in addition to any other penalties the authority may seek under its agreements with the applicant), or (ii) has a reservation of credits terminated by the authority. (minus 10 points a period of three years after the credits are returned to the authority)~~.~~

e. Any applicant that includes a management company in its application that is rated unsatisfactory by the executive director or if the ownership of any applicant includes a principal that is or was a principal in a development that hired a management company to manage a tax credit development after such management company received a rating of unsatisfactory from the executive director during the compliance period and extended use period of such development. (minus 25 points)

f. Any applicant that includes a principal that was a principal in a development for which the actual cost of construction (as certified in the Independent Auditor's Report with attached Certification of Sources and Uses that is submitted in connection with the Owner's Application for IRS Form 8609) exceeded the applicable cost limit by 5.0% or more (minus 50 points for a period of three calendar years after December 31 of the year the cost certification is complete; provided, however, if the Board of Commissioners determines that such overage was outside of the applicant's control based upon documented extenuating circumstances, no negative points will be assessed.)

6. Efficient use of resources.

a. The percentage by which the total of the amount of credits per low-income housing unit (the "per unit credit amount") of the proposed development is less than the standard per unit credit amounts established by the executive director for a given unit type, based upon the number of such unit types in the proposed development. (200 points multiplied by the percentage by which the total amount of the per unit credit amount of the proposed development is less than the applicable standard per unit credit amount established by the executive director, negative points will be assessed using the percentage by which the total amount of the per unit credit amount of the proposed development exceeds the applicable standard per unit credit amount established by the executive director.)

b. The percentage by which the cost per low-income housing unit ~~(the "per unit cost")~~ (per unit), adjusted by the authority for location, of the proposed development is less than the standard per unit cost amounts established by the executive director for a given unit type, based upon the number of such unit types in the proposed development. (100 points multiplied by the percentage by which the total amount of the per unit cost of the

proposed development is less than the applicable standard per unit cost amount established by the executive director; negative points will be assessed using the percentage by which the total amount of the per unit cost amount of the proposed development exceeds the applicable standard per unit cost amount established by the executive director.)

The executive director may use a standard per square foot credit amount and a standard per square foot cost amount in establishing the per unit credit amount and the per unit cost amount in subdivision 6 above. For the purpose of calculating the points to be assigned pursuant to such subdivision 6 above, all credit amounts shall include any credits previously allocated to the development.

7. Bonus points.

a. Commitment by the applicant to impose income limits on the low-income housing units throughout the extended use period (as defined in the IRC) below those required by the IRC in order for the development to be a qualified low-income development. Applicants receiving points under this subdivision 7 a may not receive points under subdivision 7 b below. (Up to 50 points, the product of (i) 100 multiplied by (ii) the percentage of housing units in the proposed development both rent restricted to and occupied by households at or below 50% of the area median gross income; plus one point for each percentage point of such housing units in the proposed development that are further restricted to rents at or below 30% of 40% of the area median gross income up to an additional 10 points.) If the applicant commits to providing housing units in the proposed development both rent-restricted to and occupied by households at or below 30% of the area median gross income and that are not subsidized by project-based rental assistance. (plus 1 point for each percentage point of such housing units in the proposed development, up to an additional 10 points)

b. Commitment by the applicant to impose rent limits on the low-income housing units throughout the extended use period (as defined in the IRC) below those required by the IRC in order for the development to be a qualified low-income development. Applicants receiving points under this subdivision 7 b may not receive points under subdivision 7 a. (Up to 25 points, the product of (i) 50 multiplied by (ii) the percentage of housing units in the proposed development rent restricted to households at or below 50% of the area median gross income; plus one point for each percentage point of such housing units in the proposed development that are further restricted to rents at or below 30% of 40% of the area median gross income up to an additional 10 points. Points for proposed developments in low-income jurisdictions shall be two times the points calculated in the preceding sentence, up to 50 points.)

c. Commitment by the applicant to maintain the low-income housing units in the development as a qualified low-income housing development beyond the 30-year extended use period (as defined in the IRC). Applicants receiving points under this subdivision 7 c may not receive bonus points under subdivision 7 d. (40 points for a 10-year commitment beyond the 30-year extended use period or 50 points for a 20-year commitment beyond the 30-year extended use period.)

d. Participation by a local housing authority or qualified nonprofit organization (substantially based or active in the community with at least a 10% ownership interest in the general partnership interest of the partnership) and a commitment by the applicant to sell the proposed development pursuant to an executed, recordable option or right of first refusal to such local housing authority or qualified nonprofit organization or to a wholly owned subsidiary of such organization or authority, at the end of the 15-year compliance period, as defined by IRC, for a price not to exceed the outstanding debt and exit taxes of the for-profit entity. The applicant must record such option or right of first refusal immediately after the low-income housing commitment described in 13VAC10-180-70. Applicants receiving points under this subdivision 7 d may not receive bonus points under subdivision 7 c. (60 points; plus five points if the local housing authority or qualified nonprofit organization submits a homeownership plan satisfactory to the authority in which the local housing authority or qualified nonprofit organization commits to sell the units in the development to tenants.)

e. Any development participating in the Rental Assistance Demonstration (RAD) program, or other conversion to project-based vouchers or project-based rental assistance approved by the authority, competing in the local housing authority pool will receive an additional 10 points. Applicants must show proof of a commitment to enter into housing assistance payment ~~(CHAP)~~ or a RAD conversion commitment ~~(RCC)~~.

In calculating the points for subdivisions 7 a and b above, any units in the proposed development required by the locality to exceed 60% of the area median gross income will not be considered when calculating the percentage of low-income units of the proposed development with incomes below those required by the IRC in order for the development to be a qualified low-income development, provided that the locality submits evidence satisfactory to the authority of such requirement.

After points have been assigned to each application in the manner described above, the executive director shall compute the total number of points assigned to each such application. Any application that is assigned a total number of points less than a threshold amount of 425 points (325 points for

developments financed with tax-exempt bonds in such amount so as not to require under the IRC an allocation of credits hereunder) shall be rejected from further consideration hereunder and shall not be eligible for any reservation or allocation of credits.

[~~8. Innovation. For calendar years 2019, 2020, and 2021, the authority establishes an innovation pool equal to the additional 12.5% of credits established by the federal Consolidated Appropriations Act of 2018. Any applicant intending to submit an application in a particular year's competitive round and having completed the local notification information process may self-select to first compete in the innovation pool. Applications for the innovation pool will be due prior to the deadline for the competitive pool on a date determined by the authority. The authority will evaluate each application in the innovation pool, without scoring it on the traditional points scale, to determine and rank the uniqueness and innovative nature of the development concept based upon the parameters set forth in this subdivision 8. The developments meeting the authority's threshold for innovation will be ranked highest to lowest and only those developments for which there are sufficient credits in the pool to fully fund such developments will be awarded credits. However, the application must meet all the requirements of the IRC and threshold score. The authority may also establish a review committee comprised of external real estate professionals, academic leaders, and other individuals knowledgeable of real estate development, design, construction, accessibility, energy efficiency, or management to assist the authority in determining and ranking the innovative nature of the development. Factors for consideration:~~

~~a. Innovative construction methods or materials that reduce the traditional construction time or construction cost of the development while maintaining sustainability;~~

~~b. Having more than 50% of funding committed to the development at the time of application;~~

~~c. Regional collaboration and support;~~

~~d. Utilizing unique up-zoning activities promoting greater density (e.g., a higher number of units per acre than otherwise permitted by zoning);~~

~~e. Ability of the development to address an unmet need of an underserved population or geographic location;~~

~~f. Unique or innovative tenant services, tenant selection criteria, or eviction policies;~~

~~g. Demonstrated capacity of the applicant to complete the proposed development and financial feasibility of the development with the innovative components;~~

~~h. Extent to which the proposed development would be at a competitive or financial disadvantage relative to developments considered in the other traditional competitive pools; and~~

~~i. The proposed development's contribution to the authority's identified mission and goals.~~

~~Applicants in the innovation pool may amend their applications prior to submission for competition in the remaining pools. After review of all applications in the innovation pool, the authority may elect to not award any credits in the innovation pool or to less than fully fund the pool and any unused credits will move to the remaining pools.~~]

During its review of the submitted applications in all pools, the authority may conduct its own analysis of the demand for the housing units to be produced by each applicant's proposed development. Notwithstanding any conclusion in the market study submitted with an application, if the authority determines that, based upon information from its own loan portfolio or its own market study, inadequate demand exists for the housing units to be produced by an applicant's proposed development, the authority may exclude and disregard the application for such proposed development.

During its review of the submitted applications in all pools, the authority may conduct a site visit to the applicant's proposed development. Notwithstanding any conclusion in any environmental site assessment submitted with an application, if the authority determines that the applicant's proposed development presents health or safety concerns for potential tenants of the development, the authority may exclude and disregard the application for such proposed development.

The executive director may exclude and disregard any application that he determines is not submitted in good faith or that he determines would not be financially feasible.

Upon assignment of points to all of the applications, the executive director shall rank the applications based on the number of points so assigned. If any pools shall have been established, each application shall be assigned to a pool and, if any, to the appropriate tier within such pool and shall be ranked within such pool or tier, if any. The amount of credits made available to each pool will be determined by the executive director. Available credits will include unreserved per capita dollar amount credits from the current calendar year under § 42(h)(3)(C)(i) of the IRC, any unreserved per capita credits from previous calendar years, and credits returned to the authority prior to the final ranking of the applications and may include up to 40% of next calendar year's per capita credits as shall be determined by the executive director. Those applications assigned more points shall be ranked higher than those applications assigned fewer points. However, if any set-asides established by the executive director cannot be satisfied after ranking the applications based on the number of points, the executive

director may rank as many applications as necessary to meet the requirements of such set-aside (selecting the highest ranked application, or applications, meeting the requirements of the set-aside) over applications with more points.

In the event of a tie in the number of points assigned to two or more applications within the same pool, or, if none, within the Commonwealth, and in the event that the amount of credits available for reservation to such applications is determined by the executive director to be insufficient for the financial feasibility of all of the developments described therein, the authority shall, to the extent necessary to fully utilize the amount of credits available for reservation within such pool or, if none, within the Commonwealth, select one or more of the applications with the highest combination of points from subdivision 7 ~~above~~, and each application so selected shall receive (in order based upon the number of such points, beginning with the application with the highest number of such points) a reservation of credits. If two or more of the tied applications receive the same number of points from subdivision 7 ~~above~~ and if the amount of credits available for reservation to such tied applications is determined by the executive director to be insufficient for the financial feasibility of all the developments described therein, the executive director shall select one or more of such applications by lot, and each application so selected by lot shall receive (in order of such selection by lot) a reservation of credits.

For each application which may receive a reservation of credits, the executive director shall determine the amount, as of the date of the deadline for submission of applications for reservation of credits, to be necessary for the financial feasibility of the development and its viability as a qualified low-income development throughout the credit period under the IRC. In making this determination, the executive director shall consider the sources and uses of the funds, the available federal, state and local subsidies committed to the development, the total financing planned for the development as well as the investment proceeds or receipts expected by the authority to be generated with respect to the development, and the percentage of the credit dollar amount used for development costs other than the costs of intermediaries. He shall also examine the development's costs, including developer's fees and other amounts in the application, for reasonableness, and if he determines that such costs or other amounts are unreasonably high, he shall reduce them to amounts that he determines to be reasonable. The executive director shall review the applicant's projected rental income, operating expenses and debt service for the credit period. The executive director may establish such criteria and assumptions as he shall deem reasonable for the purpose of making such determination, including~~, without limitation,~~ criteria as to the reasonableness of fees and profits and assumptions as to the amount of net syndication proceeds to be received (based upon such percentage of the credit dollar amount used for development costs, other than the costs of intermediaries, as the executive director shall determine to be reasonable for the proposed development), increases in the market value of the development, and increases in operating expenses, rental income and, in the case of applications without firm financing commitments (as defined hereinabove) at fixed interest rates, debt service on the proposed mortgage loan. The executive director may, if he deems it appropriate, consider the development to be a part of a larger development. In such a case, the executive director may consider, examine, review and establish any or all of the foregoing items as to the larger development in making such determination for the development.

[~~The following~~ Maximum] developer's [~~fees may not~~ fee calculations will] be [~~exceeded in~~ indicated on] the application [~~: (i) for 4.0% developments, $20,000 per unit for units zero through 60; $15,000 per unit for units 61 through 120; and $10,000 per unit for any units above 120; and (ii) for 9.0% developments, $20,000 per unit for units zero through 30; $15,000 per unit for units 31 through 60, and $10,000 per unit for any units above 60. For 4.0% developments above 120 units and 9.0% developments above 60 units, the developer fee shall be subject~~ form, instructions, or other communication available] to the [~~authority's determination~~ public. Notwithstanding such calculations] of [~~reasonableness, and the developer per unit may be lower~~ developer's fee, (i) no more] than [~~set forth above. However, in no event shall the developer fee~~ $3 million developer's fee may be included in the development's eligible basis, (ii) no developer's fee may exceed $5 million, and (iii) no developer's fee may] exceed 15% of the development's total development cost, as determined by the authority.

At such time or times during each calendar year as the executive director shall designate, the executive director shall reserve credits to applications in descending order of ranking within each pool and tier, if applicable, until either substantially all credits therein are reserved or all qualified applications therein have received reservations. (For the purpose of the preceding sentence, if there is not more than a de minimis amount, as determined by the executive director, of credits remaining in a pool after reservations have been made, "substantially all" of the credits in such pool shall be deemed to have been reserved.) The executive director may rank the applications within pools at different times for different pools and may reserve credits, based on such rankings, one or more times with respect to each pool. The executive director may also establish more than one round of review and ranking of applications and reservation of credits based on such rankings, and he shall designate the amount of credits to be made available for reservation within each pool during each such round. The amount reserved to each such application shall be equal to the lesser of (i) the amount requested in the application or (ii) an amount determined by the executive director, as of the date of application, to be

necessary for the financial feasibility of the development and its viability as a qualified low-income development throughout the credit period under the IRC; provided, however, that in no event shall the amount of credits so reserved exceed the maximum amount permissible under the IRC.

~~Effective until January 1, 2018, not more than 20% of the credits in any pool may be reserved to developments intended to provide elderly housing, unless the feasible credit amount, as determined by the executive director, of the highest ranked elderly housing development in any pool exceeds 20% of the credits in such pool, then such elderly housing development shall be the only elderly housing development eligible for a reservation of credits from such pool. However, if credits remain available for reservation after all eligible nonelderly housing developments receive a reservation of credits, such remaining credits may be made available to additional elderly housing developments. The above limitation of credits available for elderly housing shall not include elderly housing developments with project based subsidy providing rental assistance for at least 20% of the units that are submitted as rehabilitation developments or assisted living facilities licensed under Chapter 17 (§ 63.2 1700 et seq.) of Title 63.2 of the Code of Virginia.~~

If the amount of credits available in any pool is determined by the executive director to be insufficient for the financial feasibility of the proposed development to which such available credits are to be reserved, the executive director may move the proposed development and the credits available to another pool. If any credits remain in any pool after moving proposed developments and credits to another pool, the executive director may for developments that meet the requirements of § 42(h)(1)(E) of the IRC only, reserve the remaining credits to any proposed ~~development(s)~~ developments scoring at or above the minimum point threshold established by this chapter without regard to the ranking of such application with additional credits from the Commonwealth's annual state housing credit ceiling for the following year in such an amount necessary for the financial feasibility of the proposed ~~development, or~~ developments. However, the reservation of credits from the Commonwealth's annual state housing credit ceiling for the following year shall be in the reasonable discretion of the executive director if he determines it to be in the best interest of the plan. In the event a reservation or an allocation of credits from the current year or a prior year is reduced, terminated, or canceled, the executive director may substitute such credits for any credits reserved from the following year's annual state housing credit ceiling.

In the event that during any round of application review and ranking the amount of credits reserved within any pools is less than the total amount of credits made available therein during such round, the executive director may (i) leave such unreserved credits in such pools for reservation and allocation in any subsequent round ~~or rounds~~, (ii) redistribute such unreserved credits to such other ~~pool or~~ pools as the executive director may designate, (iii) supplement such unreserved credits in such pools with additional credits from the Commonwealth's annual state housing credit ceiling for the following year for reservation and allocation if in the reasonable discretion of the executive director, it serves the best interest of the plan, or (iv) carry over such unreserved credits to the next succeeding calendar year for inclusion in the state housing credit ceiling (as defined in § 42(h)(3)(C) of the IRC) for such year.

Notwithstanding anything contained herein, the total amount of credits that may be awarded in any credit year after credit year 2001 to any applicant or to any related applicants for one or more developments shall not exceed 15% of Virginia's per capita dollar amount of credits for such credit year ~~(the "credit cap")~~ (credit cap). However, if the amount of credits to be reserved in any such credit year to all applications assigned a total number of points at or above the threshold amount set forth above shall be less than Virginia's dollar amount of credits available for such credit year, then the authority's board of commissioners may waive the credit cap to the extent it deems necessary to reserve credits in an amount at least equal to such dollar amount of credits. Applicants shall be deemed to be related if any principal in a proposed development or any person or entity related to the applicant or principal will be a principal in any other proposed development or developments. For purposes of this paragraph, a principal shall also include any person or entity who, in the determination of the executive director, has exercised or will exercise, directly or indirectly, substantial control over the applicant or has performed or will perform (or has assisted or will assist the applicant in the performance of), directly or indirectly, substantial responsibilities or functions customarily performed by applicants with respect to applications or developments. For the purpose of determining whether any person or entity is related to the applicant or principal, persons or entities shall be deemed to be related if the executive director determines that any substantial relationship existed, either directly between them or indirectly through a series of one or more substantial relationships (e.g., if party A has a substantial relationship with party B and if party B has a substantial relationship with party C, then A has a substantial relationship with both party B and party C), at any time within three years of the filing of the application for the credits. In determining in any credit year whether an applicant has a substantial relationship with another applicant with respect to any application for which credits were awarded in any prior credit year, the executive director shall determine whether the applicants were related as of the date of the filing of such prior credit year's application or within three years prior thereto and shall not consider any relationships or any changes in relationships subsequent to such date. Substantial relationships shall include~~, but not be limited to,~~ the following relationships (in each of the

following relationships, the persons or entities involved in the relationship are deemed to be related to each other): (i) the persons are in the same immediate family (including~~, without limitation,~~ a spouse, children, parents, grandparents, grandchildren, brothers, sisters, uncles, aunts, nieces, and nephews) and are living in the same household; (ii) the entities have one or more common general partners or members (including related persons and entities), or the entities have one or more common owners that (by themselves or together with any other related persons and entities) have, in the aggregate, 5.0% or more ownership interest in each entity; (iii) the entities are under the common control (e.g., the same ~~person or~~ persons and any related persons serve as a majority of the voting members of the boards of such entities or as chief executive officers of such entities) of one or more persons or entities (including related persons and entities); (iv) the person is a general partner, member or employee in the entity or is an owner (by himself or together with any other related persons and entities) of 5.0% or more ownership interest in the entity; (v) the entity is a general partner or member in the other entity or is an owner (by itself or together with any other related persons and entities) of 5.0% or more ownership interest in the other entity; or (vi) the person or entity is otherwise controlled, in whole or in part, by the other person or entity. In determining compliance with the credit cap with respect to any application, the executive director may exclude any person or entity related to the applicant or to any principal in such applicant if the executive director determines that (i) such person or entity will not participate, directly or indirectly, in matters relating to the applicant or the ownership of the development to be assisted by the credits for which the application is submitted, (ii) such person or entity has no agreement or understanding relating to such application or the tax credits requested therein, and (iii) such person or entity will not receive a financial benefit from the tax credits requested in the application. A limited partner or other similar investor shall not be determined to be a principal and shall be excluded from the determination of related persons or entities unless the executive director shall determine that such limited partner or investor will, directly or indirectly, exercise control over the applicant or participate in matters relating to the ownership of the development substantially beyond the degree of control or participation that is usual and customary for limited partners or other similar investors with respect to developments assisted by the credits. If the award of multiple applications of any applicant or related applicants in any credit year shall cause the credit cap to be exceeded, such applicant ~~or applicants~~ shall, upon notice from the authority, jointly designate those applications for which credits are not to be reserved so that such limitation shall not be exceeded. Such notice shall specify the date by which such designation shall be made. In the absence of any such designation by the date specified in such notice, the executive director shall make such designation as he shall determine to best serve the interests of the program. Each applicant and each principal therein shall make such certifications, shall disclose such facts and shall submit such documents to the authority as the executive director may require to determine compliance with the credit cap. If an applicant or any principal therein makes any misrepresentation to the authority concerning such applicant's or principal's relationship with any other person or entity, the executive director may reject any or all of such applicant's pending applications for reservation or allocation of credits, may terminate any or all reservations of credits to the applicant, and may prohibit such applicant, the principals therein and any persons and entities then or thereafter having a substantial relationship (in the determination of the executive director as described above) with the applicant or any principal therein from submitting applications for credits for such period of time as the executive director shall determine.

Within a reasonable time after credits are reserved to any applicants' applications, the executive director shall notify each applicant for such reservations of credits either of the amount of credits reserved to such applicant's application (by issuing to such applicant a written binding commitment to allocate such reserved credits subject to such terms and conditions as may be imposed by the executive director therein, by the IRC and by this chapter) or, as applicable, that the applicant's application has been rejected or excluded or has otherwise not been reserved credits in accordance herewith. The written binding commitment shall prohibit any transfer, direct or indirect, of partnership interests (except those involving the admission of limited partners) prior to the placed-in-service date of the proposed development unless the transfer is consented to by the executive director. The written binding commitment shall further limit the developers' fees to the amounts established during the review of the applications for reservation of credits and such amounts shall not be increased unless consented to by the executive director.

If credits are reserved to any applicants for developments that have also received an allocation of credits from prior years, the executive director may reserve additional credits from the current year equal to the amount of credits allocated to such developments from prior years, provided such previously allocated credits are returned to the authority. Any previously allocated credits returned to the authority under such circumstances shall be placed into the credit pools from which the current year's credits are reserved to such applicants.

The executive director shall make a written explanation available to the general public for any allocation of housing credit dollar amount that is not made in accordance with established priorities and selection criteria of the authority.

The authority's board shall review and consider the analysis and recommendation of the executive director for the reservation of credits to an applicant, and, if it concurs with such recommendation, it shall by resolution ratify the

reservation by the executive director of the credits to the applicant, subject to such terms and conditions as it shall deem necessary or appropriate to assure compliance with the aforementioned binding commitment issued or to be issued to the applicant, the IRC and this chapter. If the board determines not to ratify a reservation of credits or to establish any such terms and conditions, the executive director shall so notify the applicant.

The executive director may require the applicant to make a good faith deposit or to execute such contractual agreements providing for monetary or other remedies as it may require, or both, to assure that the applicant will comply with all requirements under the IRC, this chapter and the binding commitment (including~~, without limitation,~~ any requirement to conform to all of the representations, commitments and information contained in the application for which points were assigned pursuant to this section). Upon satisfaction of all such aforementioned requirements (including any post-allocation requirements), such deposit shall be refunded to the applicant or such contractual agreements shall terminate, or both, as applicable.

If, as of the date the application is approved by the executive director, the applicant is entitled to an allocation of the credits under the IRC, this chapter and the terms of any binding commitment that the authority would have otherwise issued to such applicant, the executive director may at that time allocate the credits to such qualified low-income buildings or development without first providing a reservation of such credits. This provision in no way limits the authority of the executive director to require a good faith deposit or contractual agreement, or both, as described in the preceding paragraph, nor to relieve the applicant from any other requirements hereunder for eligibility for an allocation of credits. Any such allocation shall be subject to ratification by the board in the same manner as provided above with respect to reservations.

The executive director may require that applicants to whom credits have been reserved shall submit from time to time or at such specified times as he shall require, written confirmation and documentation as to the status of the proposed development and its compliance with the application, the binding commitment and any contractual agreements between the applicant and the authority. If on the basis of such written confirmation and documentation as the executive director shall have received in response to such a request, or on the basis of such other available information, or both, the executive director determines any or all of the buildings in the development that were to become qualified low-income buildings will not do so within the time period required by the IRC or will not otherwise qualify for such credits under the IRC, this chapter or the binding commitment, then the executive director may (i) terminate the reservation of such credits and draw on any good faith deposit, or (ii) substitute the reservation of credits from the current credit year with a reservation of credits from a future credit year if the delay is caused by a lawsuit beyond the applicant's control that prevents the applicant from proceeding with the development. If, in lieu of or in addition to the foregoing determination, the executive director determines that any contractual agreements between the applicant and the authority have been breached by the applicant, whether before or after allocation of the credits, he may seek to enforce any and all remedies to which the authority may then be entitled under such contractual agreements.

The executive director may establish such deadlines for determining the ability of the applicant to qualify for an allocation of credits as he shall deem necessary or desirable to allow the authority sufficient time, in the event of a reduction or termination of the applicant's reservation, to reserve such credits to other eligible applications and to allocate such credits pursuant thereto.

Any material changes to the development, as proposed in the application, occurring subsequent to the submission of the application for the credits therefor shall be subject to the prior written approval of the executive director. As a condition to any such approval, the executive director may, as necessary to comply with this chapter, the IRC, the binding commitment and any other contractual agreement between the authority and the applicant, reduce the amount of credits applied for or reserved or impose additional terms and conditions with respect thereto. If such changes are made without the prior written approval of the executive director, he may terminate or reduce the reservation of such credits, impose additional terms and conditions with respect thereto, seek to enforce any contractual remedies to which the authority may then be entitled, draw on any good faith deposit, or any combination of the foregoing.

In the event that any reservation of credits is terminated or reduced by the executive director under this section, he may reserve, allocate or carry over, as applicable, such credits in such manner as he shall determine consistent with the requirements of the IRC and this chapter.

Notwithstanding the provisions of this section, the executive director may make a reservation of credits in an accessible supportive housing pool (ASH pool) to any applicant that proposes a nonelderly development that (i) will be assisted by ~~HUD project-based vouchers or another form of~~ a documented and binding ~~federal or state project-based rent subsidies~~ form of rental assistance in order to ensure occupancy by extremely low-income persons; (ii) conforms to HUD regulations interpreting the accessibility requirements of § 504 of the Rehabilitation Act; ~~and~~ (iii) will be actively marketed to people with disabilities in accordance with a plan submitted as part of the application for credits and approved by the executive director for ~~either (a) at least 25% of the units in the development or (b) if HUD Section 811 funds are~~

~~providing the rent subsidies, at least 15% but not more than 25% of the units in the development.~~ at least 15% of the units in the development; (iv) has a principal with a demonstrated capacity for supportive housing evidenced by a certification from a certifying body acceptable to the executive director or other preapproved source; and (v) for which the applicant has completed the authority's supportive housing certification form. Any such reservations made in any calendar year may be up to 6.0% of the Commonwealth's annual state housing credit ceiling for the applicable credit year. However, such reservation will be for credits from the Commonwealth's annual state housing credit ceiling from the following calendar year. If the ASH pool application deadline is simultaneous with the deadline for the other pools, the unsuccessful applicants in the ASH pool will also compete in the applicable geographic pool.

[Notwithstanding the provisions of this section, the executive director may make reservations of credits to developments having unique and innovative development concepts, such as innovative construction methods or materials; unique or innovative tenant services, tenant selection criteria, or eviction policies; or otherwise innovatively contributing to the authority's identified mission and goals. The applications for such credits must meet all the requirements of the IRC and threshold score. The authority shall also establish a review committee comprised of external real estate professionals, academic leaders, and other individuals knowledgeable of real estate development, design, construction, accessibility, energy efficiency, or management to assist the authority in determining and ranking the innovative nature of the development. Such reservations will be for credits from the next year's per capita credits and may not exceed 12.5% of the credits expected to be available for that following calendar year. Such reservations shall not be considered in the executive director's determination that no more than 40% of the next calendar year's per capita credits have been prereserved.]

13VAC10-180-70. Allocation of credits.

At such time as one or more of an applicant's buildings or an applicant's development which has received a reservation of credits is (i) placed in service or satisfies the requirements of § 42(h)(1)(E) of the IRC and (ii) meets all of the preallocation requirements of this chapter, the binding commitment and any other applicable contractual agreements between the applicant and the authority, the applicant shall so advise the authority, shall request the allocation of all of the credits so reserved or such portion thereof to which the applicant's buildings or development is then entitled under the IRC, this chapter, the binding commitment and the aforementioned contractual agreements, if any, and shall submit such application, certifications~~,~~ (including an independent certified public accountant's certification of applicant's actual cost and an independent certified public accountant's certification of the general contractor's actual costs), legal and accounting opinions, evidence as to costs, a breakdown of sources and uses of funds, pro forma financial statements setting forth anticipated cash flows, and other documentation as the executive director shall require in order to determine that the applicant's buildings or development is entitled to such credits as described above. The applicant shall certify to the authority the full extent of all federal, state and local subsidies which apply (or which the applicant expects to apply) with respect to the buildings or the development.

As of the date of allocation of credits to any building or development and as of the date such building or such development is placed in service, the executive director shall determine the amount of credits to be necessary for the financial feasibility of the development and its viability as a qualified low-income housing development throughout the credit period under the IRC. In making such determinations, the executive director shall consider the sources and uses of the funds, the available federal, state and local subsidies committed to the development, the total financing planned for the development as well as the investment proceeds or receipts expected by the authority to be generated with respect to the development and the percentage of the credit dollar amount used for development costs other than the costs of intermediaries. He shall also examine the development's costs, including developer's fees and other amounts in the application, for reasonableness and, if he determines that such costs or other amounts are unreasonably high, he shall reduce them to amounts that he determines to be reasonable. The executive director shall review the applicant's projected rental income, operating expenses and debt service for the credit period. The executive director may establish such criteria and assumptions as he shall then deem reasonable (or he may apply the criteria and assumptions he established pursuant to 13VAC10-180-60) for the purpose of making such determinations, including~~, without limitation,~~ criteria as to the reasonableness of fees and profits and assumptions as to the amount of net syndication proceeds to be received (based upon such percentage of the credit dollar amount used for development costs, other than the costs of intermediaries, as the executive director shall determine to be reasonable for the proposed development), increases in the market value of the development, and increases in operating expenses, rental income and, in the case of applications without firm financing commitments (as defined in 13VAC10-180-60) at fixed interest rates, debt service on the proposed mortgage loan. The amount of credits allocated to the applicant shall in no event exceed such amount as so determined by the executive director by more than a de minimis amount of not more than $100.

Prior to allocating credits to an applicant, the executive director shall require the applicant to execute and deliver to the authority a valid IRS Form 8821, Tax Information Authorization, naming the authority as the appointee to receive tax information. The Forms 8821 of all applicants will

be forwarded to the IRS, which will authorize the IRS to furnish the authority with all IRS information pertaining to the applicants' developments, including audit findings and assessments.

Prior to allocating the credits to an applicant, the executive director shall require the applicant to execute, deliver and record among the land records of the appropriate jurisdiction or jurisdictions an extended low-income housing commitment in accordance with the requirements of the IRC. Such commitment shall require that the applicable fraction (as defined in the IRC) for the buildings for each taxable year in the extended use period (as defined in the IRC) will not be less than the applicable fraction specified in such commitment and which prohibits both (i) the eviction or the termination of tenancy (other than for good cause) of an existing tenant of a low-income unit and (ii) any increase in the gross rent with respect to such unit not otherwise permitted under the IRC. The amount of credits allocated to any building shall not exceed the amount necessary to support such applicable fraction, including any increase thereto pursuant to § 42(f)(3) of the IRC reflected in an amendment to such commitment. The commitment shall provide that the extended use period will end on the day 15 years after the close of the compliance period (as defined in the IRC) or on the last day of any longer period of time specified in the application during which low-income housing units in the development will be occupied by tenants with incomes not in excess of the applicable income limitations; provided, however, that the extended use period for any building shall be subject to termination, in accordance with the IRC, ~~(i)~~ on the date the building is acquired by foreclosure or instrument in lieu thereof unless a determination is made pursuant to the IRC that such acquisition is part of an agreement with the current owner thereof, a purpose of which is to terminate such period ~~or (ii) on the last day of the one-year period following the written request by the applicant as specified in the IRC (such period in no event beginning earlier than the end of the fourteenth year of the compliance period) if the authority is unable to present during such one-year period a qualified contract (as defined in the IRC) for the acquisition of the building by any person who will continue to operate the low-income portion thereof as a qualified low-income building~~. In addition, such termination shall not be construed to permit, prior to close of the three-year period following such termination, the eviction or termination of tenancy of any existing tenant of any low-income housing unit other than for good cause or any increase in the gross rents over the maximum rent levels then permitted by the IRC with respect to such low-income housing units. Such commitment shall contain a waiver of the applicant's right to pursue a qualified contract. Such commitment shall also contain such other terms and conditions as the executive director may deem necessary or appropriate to assure that the applicant and the development conform to the representations, commitments and information in the application and comply with the requirements of the IRC and this chapter. Such commitment shall be a restrictive covenant on the buildings binding on all successors to the applicant and shall be enforceable in any state court of competent jurisdiction by individuals (whether prospective, present or former occupants) who meet the applicable income limitations under the IRC.

In accordance with the IRC, the executive director may, for any calendar year during the project period (as defined in the IRC), allocate credits to a development, as a whole, which contains more than one building. Such an allocation shall apply only to buildings placed in service during or prior to the end of the second calendar year after the calendar year in which such allocation is made, and the portion of such allocation allocated to any building shall be specified not later than the close of the calendar year in which such building is placed in service. Any such allocation shall be subject to satisfaction of all requirements under the IRC.

If the executive director determines that the buildings or development is so entitled to the credits, he shall allocate the credits (or such portion thereof to which he deems the buildings or the development to be entitled) to the applicant's qualified low-income buildings or to the applicant's development in accordance with the requirements of the IRC. If the executive director shall determine that the applicant's buildings or development is not so entitled to the credits, he shall not allocate the credits and shall so notify the applicant within a reasonable time after such determination is made. In the event that any such applicant shall not request an allocation of all of its reserved credits or whose buildings or development shall be deemed by the executive director not to be entitled to any or all of its reserved credits, the executive director may reserve or allocate, as applicable, such unallocated credits to the buildings or developments of other qualified applicants at such time or times and in such manner as he shall determine consistent with the requirements of the IRC and this chapter.

The executive director may prescribe (i) such deadlines for submissions of requests for allocations of credits for any calendar year as he deems necessary or desirable to allow sufficient processing time for the authority to make such allocations within such calendar year and (ii) such deadlines for satisfaction of all preallocation requirements of the IRC the binding commitment, any contractual agreements between the authority and the applicant and this chapter as he deems necessary or desirable to allow the authority sufficient time to allocate to other eligible applicants any credits for which the applicants fail to satisfy such requirements.

The executive director may make the allocation of credits subject to such terms as he may deem necessary or appropriate to assure that the applicant and the development comply with the requirements of the IRC.

The executive director may also (to the extent not already required under 13VAC10-180-60) require that all applicants

make such good faith deposits or execute such contractual agreements with the authority as the executive director may require with respect to the credits, (i) to ensure that the buildings or development are completed in accordance with the binding commitment, including all of the representations made in the application for which points were assigned pursuant to 13VAC10-180-60 and (ii) only in the case of any buildings or development which are to receive an allocation of credits hereunder and which are to be placed in service in any future year, to assure that the buildings or the development will be placed in service as a qualified low-income housing project (as defined in the IRC) in accordance with the IRC and that the applicant will otherwise comply with all of the requirements under the IRC.

In the event that the executive director determines that a development for which an allocation of credits is made shall not become a qualified low-income housing project (as defined in the IRC) within the time period required by the IRC or the terms of the allocation or any contractual agreements between the applicant and the authority, the executive director may terminate the allocation and rescind the credits in accordance with the IRC and, in addition, may draw on any good faith deposit and enforce any of the authority's rights and remedies under any contractual agreement. An allocation of credits to an applicant may also be cancelled with the mutual consent of such applicant and the executive director. Upon the termination or cancellation of any credits, the executive director may reserve, allocate or carry over, as applicable, such credits in such manner as he shall determine consistent with the requirements of the IRC and this chapter.

An applicant that demonstrates a legitimate change in circumstances or delay beyond their reasonable control, as determined by the authority, may return a valid reservation of prior years' tax credits between October 1 and December 31 and receive a reservation of the same amount of current or future year tax credits. The authority must determine that the applicant is capable of completing and placing the development in service within the time required by the IRC for such current or future year tax credits. However, none of the principals in the development for which credits are returned and refreshed may be a principal in an application the following calendar year and the applicant must waive the right to a qualified contract, if applicable. [The executive director may waive the one-year nonparticipation provision if the executive director determines that the delay in completing the development is materially due to the failure of a governmental entity or agency within a reasonable period of time to take an action necessary for the applicant to complete the development, despite the applicant's good faith best efforts to complete the development.]

13VAC10-180-90. Monitoring for IRS compliance.

A. Federal law requires the authority to monitor developments receiving credits for compliance with the requirements of § 42 of the IRC and notify the IRS of any noncompliance of which it becomes aware. Compliance with the requirements of § 42 of the IRC is the responsibility of the owner of the building for which the credit is allowable. The monitoring requirements set forth hereinbelow are to qualify the authority's allocation plan of credits. The authority's obligation to monitor for compliance with the requirements of § 42 of the IRC does not make the authority liable for an owner's noncompliance, nor does the authority's failure to discover any noncompliance by an owner excuse such noncompliance.

B. The owner of a low-income housing development must keep records for each qualified low-income building in the development that show for each year in the compliance period:

1. The total number of residential rental units in the building (including the number of bedrooms and the size in square feet of each residential rental unit).

2. The percentage of residential rental units in the building that are low-income units.

3. The rent charged on each residential rental unit in the building (including any utility allowances).

4. The number of occupants in each low-income unit, but only if rent is determined by the number of occupants in each unit under § 42(g)(2) of the IRC (as in effect before the amendments made by the federal Revenue Reconciliation Act of 1989).

5. The low-income unit vacancies in the building and information that shows when, and to whom, the next available units were rented.

6. The annual income certification of each low-income tenant per unit.

7. Documentation to support each low-income tenant's income certification (for example, a copy of the tenant's federal income tax return, Forms W-2, or verifications of income from third parties such as employers or state agencies paying unemployment compensation). Tenant income is calculated in a manner consistent with the determination of annual income under section 8 of the United States Housing Act of 1937, 42 USC § 1401 et seq. (section 8), not in accordance with the determination of gross income for federal income tax liability. In the case of a tenant receiving housing assistance payments under section 8, the documentation requirement of this subdivision 7 is satisfied if the public housing authority provides a statement to the building owner declaring that the tenant's income does not exceed the applicable income limit under § 42(g) of the IRC.

8. The eligible basis and qualified basis of the building at the end of the first year of the credit period.

9. The character and use of the nonresidential portion of the building included in the building's eligible basis under § 42(d) of the IRC (e.g., tenant facilities that are available on a comparable basis to all tenants and for which no separate fee is charged for use of the facilities, or facilities reasonably required by the development).

The owner of a low-income housing development must retain the records described in this subsection B for at least six years after the due date (with extensions) for filing the federal income tax return for that year. The records for the first year of the credit period, however, must be retained for at least six years beyond the due date (with extensions) for filing the federal income tax return for the last year of the compliance period of the building.

In addition, the owner of a low-income housing development must retain any original local health, safety, or building code violation reports or notices issued by the Commonwealth or local government (as described in subdivision C 6 of this section) for the authority's inspection. Retention of the original violation reports or notices is not required once the authority reviews the violation reports or notices and completes its inspection, unless the violation remains uncorrected.

C. The owner of a low-income housing development must certify annually to the authority, on the form prescribed by the authority, that, for the preceding 12-month period:

1. The development met the requirements of the 20-50 test under § 42(g)(1)(A) of the IRC ~~or,~~ the 40-60 test under § 42(g)(2)(B) of the IRC, or the income averaging test of the federal Consolidated Appropriations Act of 2018 (as limited by the executive director), whichever minimum set-aside test was applicable to the development.

2. There was no change in the applicable fraction (as defined in § 42(c)(1)(B) of the IRC) of any building in the development, or that there was a change, and a description of the change.

3. The owner has received an annual income certification from each low-income tenant, and documentation to support that certification; or, in the case of a tenant receiving section 8 housing assistance payments, the statement from a public housing authority described in subdivision 7 of subsection B of this section (unless the owner has obtained a waiver from the IRS pursuant to § 42(g)(8)(B) of the IRC).

4. Each low-income unit in the development was rent-restricted under § 42(g)(2) of the IRC.

5. All units in the development were for use by the general public (as defined in IRS Regulation § 1.42-9) and that no finding of discrimination under the Fair Housing Act has occurred for the development. (A finding of discrimination includes an adverse final decision by the Secretary of HUD, 24 CFR 180.680, an adverse final decision by a substantially equivalent state or local fair housing agency, 42 USC § 3616(a)(1), or adverse judgment from federal court.)

6. Each building in the development was suitable for occupancy, taking into account local health, safety, and building codes (or other habitability standards), and that the Commonwealth or local government unit responsible for making local health, safety, and building code inspections did not issue a violation report for any building or low-income unit in the development. (If a violation report or notice was issued by the governmental unit, the owner must attach a statement summarizing the violation report or notice or a copy of the violation report or notice to the annual certification. In addition the owner must state whether the violation has been corrected.)

7. There was no change in the eligible basis (as defined in § 42(d) of the IRC) of any building in the development, or if there was a change, the nature of the change (e.g., a common area has become commercial space or a fee is now charged for a tenant facility formerly provided without charge).

8. All tenant facilities included in the eligible basis under § 42(d) of the IRC of any building in the development, such as swimming pools, other recreational facilities, and parking areas, were provided on a comparable basis without charge to all tenants in the building.

9. If a low-income unit in the development became vacant during the year, that reasonable attempts were or are being made to rent that unit or the next available unit of comparable or smaller size to tenants having a qualifying income before any units in the development were or will be rented to tenants not having a qualifying income.

10. If the income of tenants of a low-income unit in the development increased above the limit allowed in § 42(g)(2)(D)(ii) of the IRC, the next available unit of comparable or smaller size in the development was or will be rented to tenants having a qualifying income.

11. An extended low income housing commitment as described in § 42(h)(6) of the IRC was in effect (for buildings subject to § 7108(c)(1) of the federal Omnibus Budget Reconciliation Act of 1989).

12. All units in the development were used on a nontransient basis (except for transitional housing for the homeless provided under § 42(i)(3)(B)(iii) of the IRC or single-room-occupancy units rented on a month-by-month basis under § 42(i)(3)(B)(iv) of the IRC).

Such certifications shall be made annually covering each year of the compliance period and must be made under the penalty of perjury.

In addition, each owner of a low-income housing development must provide to the authority, on a form prescribed by the authority, a certification containing such information necessary for the Commonwealth to determine the eligibility of tax credits for the first year of the development's compliance period.

D. The authority will review each certification set forth in subsection C of this section for compliance with the requirements of § 42 of the IRC. Also, the authority will conduct on-site inspections of all the buildings in the development by the end of the second calendar year following the year the last building in the development is placed in service and, for at least 20% of the development's low-income housing units, inspect the low-income certification, the documentation the owner has received to support that certification, and the rent record for the tenants in those units. In addition, at least once every three years, the authority will conduct on-site inspections of all the buildings in each low-income housing development and, for at least 20% of the development's low-income units, inspect the units, the low-income certifications, the documentation the owner has received to support the certifications, and the rent record for the tenants in those units. The authority will determine which low-income housing developments will be reviewed in a particular year and which tenant's records are to be inspected.

In addition, the authority, at its option, may request an owner of a low-income housing development not selected for the review procedure set forth above in a particular year to submit to the authority for compliance review copies of the annual income certifications, the documentation such owner has received to support those certifications and the rent record for each low-income tenant of the low-income units in their development.

All low-income housing developments may be subject to review at any time during the compliance period.

E. The authority has the right to perform, and each owner of a development receiving credits shall permit the performance of, an on-site inspection of any low-income housing development through the end of the compliance period of the building. The inspection provision of this subsection E is separate from the review of low-income certifications, supporting documents and rent records under subsection D of this section.

The owner of a low-income housing development should notify the authority when the development is placed in service. The authority reserves the right to inspect the property prior to issuing IRS Form 8609 to verify that the development conforms to the representations made in the Application for Reservation and Application for Allocation.

F. The authority will provide written notice to the owner of a low-income housing development if the authority does not receive the certification described in subsection C of this section, or does not receive or is not permitted to inspect the tenant income certifications, supporting documentation, and rent records described in subsection D of this section or discovers by inspection, review, or in some other manner, that the development is not in compliance with the provisions of § 42 of the IRC.

Such written notice will set forth a correction period which shall be that period specified by the authority during which an owner must supply any missing certifications and bring the development into compliance with the provisions of § 42 of the IRC. The authority will set the correction period for a time not to exceed 90 days from the date of such notice to the owner. The authority may extend the correction period for up to [~~6~~ six] months, but only if the authority determines there is good cause for granting the extension.

The authority will file Form 8823, "Low-Income Housing Credit Agencies Report of Noncompliance," with the IRS no later than 45 days after the end of the correction period (as described above, including any permitted extensions) and no earlier than the end of the correction period, whether or not the noncompliance or failure to certify is corrected. The authority must explain on Form 8823 the nature of the noncompliance or failure to certify and indicate whether the owner has corrected the noncompliance or failure to certify. Any change in either the applicable fraction or eligible basis under subdivisions 2 and 7 of subsection C of this section, respectively, that results in a decrease in the qualified basis of the development under § 42(c)(1)(A) of the IRC is noncompliance that must be reported to the IRS under this subsection F. If the authority reports on Form 8823 that a building is entirely out of compliance and will not be in compliance at any time in the future, the authority need not file Form 8823 in subsequent years to report that building's noncompliance.

The authority will retain records of noncompliance or failure to certify for six years beyond the authority's filing of the respective Form 8823. In all other cases, the authority must retain the certifications and records described in subsection C of this section for three years from the end of the calendar year the authority receives the certifications and records.

G. If the authority decides to enter into the agreements described below, the review requirements under subsection D of this section will not require owners to submit, and the authority is not required to review, the tenant income certifications, supporting documentation and rent records for buildings financed by Rural Development under the § 515 program, or buildings of which 50% or more of the aggregate basis (taking into account the building and the land) is financed with the proceeds of obligations the interest on which is exempt from tax under § 103 (tax-exempt bonds). In

order for a monitoring procedure to except these buildings, the authority must enter into an agreement with Rural Development or tax-exempt bond issuer. Under the agreement, Rural Development or tax-exempt bond issuer must agree to provide information concerning the income and rent of the tenants in the building to the authority. The authority may assume the accuracy of the information provided by Rural Development or the tax-exempt bond issuer without verification. The authority will review the information and determine that the income limitation and rent restriction of § 42(g)(1) and (2) of the IRC are met. However, if the information provided by Rural Development or tax-exempt bond issuer is not sufficient for the authority to make this determination, the authority will request the necessary additional income or rent information from the owner of the buildings. For example, because Rural Development determines tenant eligibility based on its definition of "adjusted annual income," rather than "annual income" as defined under section 8, the authority may have to calculate the tenant's income for purposes of § 42 of the IRC and may need to request additional income information from the owner.

H. The owners of low-income housing developments must pay to the authority such fees in such amounts and at such times as the authority shall reasonably require the owners to pay in order to reimburse the authority for the costs of monitoring compliance with § 42 of the IRC.

I. The owners of low-income housing developments that have submitted IRS Forms 8821, Tax Information Authorization, naming the authority as the appointee to receive tax information on such owners shall submit from time to time renewals of such Forms 8821 as required by the authority throughout the extended use period.

J. The requirements of this section shall continue throughout the extended use period, notwithstanding the use of the term compliance period, except to the extent modified or waived by the executive director.

13VAC10-180-110. Qualified contracts.

After the first day of the 14th year of the compliance period, an owner of a low-income housing tax credit development may seek to terminate the extended use period pursuant to § 42(h)(6)(E) of the IRC by requesting the authority to present a qualified contract for the acquisition of the low-income portion of the development, unless such right to terminate has already been waived by the owner for the tax credits allocated to such development. A request for a qualified contract shall be commenced by filing with the authority a complete application, on such ~~form or~~ forms as the executive director may from time to time prescribe or approve, together with such documents and additional information as may be requested by the authority in order to comply with the IRC and this chapter and to determine the qualified contract price in accordance with § 42(h)(6)(F) of the IRC. The executive director may reject any application from consideration for a qualified contract, if in such application, the owner does not provide the proper documentation or information on the forms prescribed by the executive director. Acceptance of the application and approval of the request shall be contingent upon the developments being in compliance with IRC requirements at the time of the application and continuing through the qualified contract process.

The application should include the following information sufficiently detailed to enable the authority to ascertain the qualified contract amount: first year IRS Form 8609 for each building, the owner's annual tax returns for all years of operation since the start of the credit period ("all years"), annual project financial statements for all years, loan documents for all secured debt during the credit period, the owner's organizational documents (original, current and all interim amendments), and accountant work papers for all years. The application may require a physical needs assessment, appraisal for the entire project, market study for the entire project, a title report showing marketable title, and a Phase I environmental assessment at the time of the original submission of the application or the executive director may permit such items to be obtained after the confirmation of the qualified contract price.

The executive director may also require the submission of a legal opinion or other assurances satisfactory to the executive director as to, among other things, compliance with the IRC and a certification, together with an opinion of an independent certified public accountant or other assurances satisfactory to the executive director, setting forth the calculation of the qualified contract amount requested in the application and certifying, among other things, that the owner is entitled to the qualified contract amount requested.

The executive director may establish criteria and assumptions to be used by the owner in the calculation of qualified contract amount, and any such criteria and assumptions may be indicated on the application form, instructions or other communication available to the public.

The authority shall charge reasonable fees in such amounts as the executive director shall determine to be necessary to cover third party costs and the authority's actual costs incurred in producing a qualified contract. Such fees shall not include any general costs associated with the general operations of the authority. Such fees shall be payable at such time or times as the executive director shall require.

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, 900 East Main Street, 11th Floor, Richmond, Virginia 23219.

FORMS (13VAC10-180)

1995 Annual Owners Certification.

Building Information Report.

Project Information Report.

Occupancy Status Report.

Previous Participation Certification.

[~~Federal Low Income Housing Tax Credit Program, Application for Reservation DRAFT (undated, filed 8/30/2018)~~

2019 Federal Low Income Housing Tax Credit Program, Application for Reservation, Version 2019-v1 (undated, filed 12/19/2018)]

VA.R. Doc. No. R19-5635; Filed December 6, 2018, 11:03 a.m.

TITLE 16. LABOR AND EMPLOYMENT

VIRGINIA WORKERS' COMPENSATION COMMISSION

Final Regulation

Title of Regulation: **16VAC30-16. Electronic Medical Billing (adding 16VAC30-16-10 through 16VAC30-16-80).**

Statutory Authority: § 65.2-605.1 of the Code of Virginia.

Effective Date: February 6, 2019.

Agency Contact: James J. Szablewicz, Chief Deputy Commissioner, Virginia Workers' Compensation Commission, 333 East Franklin Street, Richmond, VA 23219, telephone (804) 205-3097, FAX (804) 823-6936, or email james.szablewicz@workcomp.virginia.gov.

Summary:

Pursuant to Chapter 621 of the 2015 Acts of Assembly, the regulation implements infrastructure under which (i) providers of workers' compensation medical services (providers) submit billing, claims, case management, health records, and all supporting documentation electronically to employers or employers' workers' compensation insurance carriers (payers) and (ii) payers return actual payment, claim status, and remittance information electronically to providers that submit billing and required supporting documentation electronically. The regulation establishes standards and methods for electronic submissions and transactions that are consistent with the electronic medical billing and payment guidelines of the International Association of Industrial Accident Boards and Commissions. The regulation does not require any reporting to or enforcement by the Virginia Workers' Compensation Commission or any other governmental agency.

Changes since the proposed regulation (i) made December 31, 2018, a voluntary compliance date and moved the mandatory compliance date to July 1, 2019; (ii) adjusted the small provider exemption; and (iii) increased the time period within which a payer must either reject or complete an incomplete medical bill.

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

CHAPTER 16
ELECTRONIC MEDICAL BILLING

16VAC30-16-10. Effective date.

This chapter applies to all medical services and products provided on or after [~~December 31, 2018~~ July 1, 2019]. For medical services and products provided prior to [~~December 31, 2018~~ July 1, 2019], medical billing and processing shall be in accordance with the rules in effect at the time the medical service or product was provided [; however, providers and payers may voluntarily comply with the provisions of this chapter beginning on December 31, 2018].

16VAC30-16-20. Definitions.

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

"Business day" means Monday through Friday, excluding days on which a holiday is observed by the Commonwealth of Virginia.

"Clearinghouse" means a public or private entity, including a billing service, repricing company, community health management information system or community health information system, and "value-added" networks and switches, that is an agent of either the payer or the health care provider and that may perform the following functions:

1. Processes or facilitates the processing of medical billing information received from a client in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction for further processing of a bill related transaction; or

2. Receives a standard transaction from another entity and processes or facilitates the processing of medical billing information into nonstandard format or nonstandard data content for a client entity.

"CMS" means the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services, the federal agency that administers these programs.

"Companion Guide" means the Virginia Workers' Compensation Electronic Billing and Payment Companion Guides, based on International Association of Industrial Accident Boards and Commissions National Companion Guides, a separate document that gives detailed information for electronic data interchange (EDI) medical billing and payment for the workers' compensation industry using national standards and Virginia specific procedures.

"Complete electronic medical bill" means a medical bill that meets all of the criteria enumerated in 16VAC30-16-50 C.

"Electronic" means communication between computerized data exchange systems that complies with the standards enumerated in this chapter.

"Health care provider" means a person or entity, appropriately certified or licensed, as required, who provides medical services or products to an injured worker in accordance with § 65.2-603 of the Code of Virginia.

"Health care provider agent" means a person or entity that contracts with a health care provider establishing an agency relationship to process bills for services provided by the health care provider under the terms and conditions of a contract between the agent and health care provider. Such contracts may permit the agent to submit bills, request reconsideration, receive reimbursement, and seek medical dispute resolution for the health care provider services billed in accordance with §§ 65.2-605 and 65.2-605.1 of the Code of Virginia.

"Payer" means the insurer or authorized self-insured employer legally responsible for paying the workers' compensation medical bills.

"Payer agent" means any person or entity that performs medical bill related processes for the payer responsible for the bill. These processes include reporting to government agencies; electronic transmission, forwarding, or receipt of documents; review of reports; and adjudication of bills and their final payment.

"Supporting documentation" means those documents necessary for the payer to process a bill and includes any written authorization received from the third-party administrator or any other records as required by the Virginia Workers' Compensation Commission.

"Technical Report Type 3 (TR3) Implementation Guide" means an ASC X12 published document for national electronic standard formats that specifies data requirements and data transaction sets, as referenced in 16VAC30-16-30.

16VAC30-16-30. Formats for electronic medical bill processing.

A. For electronic transactions, the following electronic medical bill processing standards shall be used:

1. Billing.

a. Professional billing: The ASC X12 Standards for Electronic Data Interchange Technical Report Type 3 and Errata, Health Care Claim: Professional (837), June 2010, ASC X12, 005010X222A1.

b. Institutional or hospital billing: The ASC X12 Standards for Electronic Data Interchange Technical Report Type 3 and Errata, Health Care Claim: Institutional (837), June 2010, ASC X12, 005010X223A2.

c. Dental billing: The ASC X12 Standards for Electronic Data Interchange Technical Report Type 3 and Errata to Health Care Claim: Dental (837), June 2010, ASC X12, 005010X224A2.

d. Retail pharmacy billing: The Telecommunication Standard Implementation Guide, Version D, Release 0 (Version D.0), August 2007, National Council for Prescription Drug Programs (NCPDP) and the Batch Standard Batch Implementation Guide, Version 1, Release 2 (Version 1.2), January 2006, National Council for Prescription Drug Programs.

2. Acknowledgment.

a. Electronic responses to the ASC X12N 837 transactions.

(1) The ASC X12 Standards for Electronic Data Interchange TA1 Interchange Acknowledgment contained in the standards adopted under subdivision A 1 of this section;

(2) The ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, Implementation Acknowledgment for Health Care Insurance (999), June 2007, ASC X12N/005010X231; and

(3) The ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, Health Care Claim Acknowledgment (277CA), January 2007, ASC X12N/005010X214.

b. Electronic responses to NCPDP transactions. The response contained in the standards adopted under subdivision A 1 d of this section.

3. Electronic remittance advice: The ASC X12 Standards for Electronic Data Interchange Technical Report Type 3 Errata to Health Care Claim Payment/Advice (835), June 2010, ASC X12, 005010X221A1.

4. ASC X12 ancillary formats.

a. The ASC X12N/005010X213 Request for Additional Information (277) is used to request additional attachments that were not originally submitted with the electronic medical bill.

b. Health Claim Status Request and Response.

The use of the formats in this subdivision 4 is voluntary, and Section 2.2.2 of the Companion Guide presents an explanation of how to use them in workers' compensation.

5. Documentation submitted with an electronic medical bill in accordance with 16VAC30-16-50 E (relating to medical documentation): ASC X12N Additional Information to Support a Health Claim or Encounter (275), February 2008, ASC X12, 005010X210.

B. Payers and health care providers may exchange electronic data in a nonprescribed format by mutual agreement. All data elements required in the Virginia-prescribed formats shall be present in any mutually agreed upon format.

C. The implementation specifications for the ASC X12N and the ASC X12 Standards for Electronic Data Interchange may be obtained from the ASC X12, 7600 Leesburg Pike, Suite 430, Falls Church, VA 22043; telephone (703) 970-4480; and FAX (703) 970-4488. They are also available online at http://store.x12.org/. A fee is charged for all implementation specifications.

D. The implementation specifications for the retail pharmacy standards may be obtained from the National Council for Prescription Drug Programs, 9240 East Raintree Drive, Scottsdale, AZ 85260; telephone (480) 477-1000; and FAX (480) 767-1042. They are also available online at http://www.ncpdp.org. A fee is charged for all implementation specifications.

E. Nothing in this section will prohibit payers and health care providers from using a direct data entry methodology for complying with the requirements of this section, provided the methodology complies with the data content requirements of the formats enumerated in subsection A of this section and this chapter.

F. The most recent standard for the formats in subsection A of this section shall be used, commencing on the effective date of the applicable standard as published in the Code of Federal Regulations.

16VAC30-16-40. Billing code sets.

Billing codes and modifier systems identified in this section are valid codes for the specified workers' compensation transactions, in addition to any code sets defined by the standards in 16VAC30-16-30.

1. "CDT-4 Codes" are codes and nomenclature prescribed by the American Dental Association.

2. "CPT-4 Codes" are the procedural terminology and codes contained in the "Current Procedural Terminology, Fourth Edition," as published by the American Medical Association.

3. "Diagnosis Related Group" or "DRG" is the inpatient classification scheme used by CMS for hospital inpatient reimbursement. The DRG system classifies patients based on principal diagnosis, surgical procedure, age, presence of comorbidities and complications, and other pertinent data.

4. "Healthcare Common Procedure Coding System" or "HCPCS" is a coding system that describes products, supplies, procedures, and health professional services and that includes the American Medical Association's Physician "Current Procedural Terminology, Fourth Edition," CPT-4 codes, alphanumeric codes, and related modifiers.

5. "ICD-10-CM/PCS Codes" are diagnosis and procedure codes in the International Classification of Diseases, Tenth Edition, Clinical Modification/Procedure Coding System maintained and published by the U.S. Department of Health and Human Services.

6. "NDC" are National Drug Codes of the U.S. Food and Drug Administration.

7. "Revenue Codes" is the four-digit coding system developed and maintained by the National Uniform Billing Committee for billing inpatient and outpatient hospital services, home health services, and hospice services.

8. "National Uniform Billing Committee Codes" are a code structure and instructions established for use by the National Uniform Billing Committee, such as occurrence codes, condition codes, or prospective payment indicator codes. As of [~~(insert effective date of final regulation)~~ February 6, 2019], these are known as UB04 codes.

16VAC30-16-50. Electronic medical billing, reimbursement, and documentation.

A. Applicability.

1. This section outlines the exclusive process for the initial exchange of electronic medical bill and related payment processing data for professional, institutional or hospital, pharmacy, and dental services [provided to injured workers in accordance with § 65.2-603 of the Code of Virginia].

2. [~~Payers~~ Unless exempted from this process in accordance with subdivision B 2 of this section, payers] or their agents shall:

a. Accept electronic medical bills submitted in accordance with the adopted standards;

b. Transmit acknowledgments and remittance advice in compliance with the adopted standards in response to electronically submitted medical bills; and

c. Support methods to receive electronic documentation required for the adjudication of a bill, as described in 16VAC30-16-80.

3. Unless exempted from this process in accordance with [~~subsection~~ subdivision] B [1] of this section, a health care provider shall:

a. Implement a software system capable of exchanging medical bill data in accordance with the adopted standards or contract with a clearinghouse to exchange its medical bill data;

b. Submit medical bills as provided in 16VAC30-16-30 A 1 to any payers that have established connectivity to the health care provider's system or clearinghouse;

c. Submit required documentation in accordance with subsection E of this section; and

d. Receive and process any acceptance or rejection acknowledgment from the payer.

4. Payers shall be able to exchange electronic data by [~~December 31, 2018~~ July 1, 2019, unless exempted from the process in accordance with subdivision B 2 of this section].

5. Health care providers or their agents shall be able to exchange electronic data by [~~December 31, 2018~~ July 1, 2019], unless exempted from the process in accordance with [~~subsection~~ subdivision] B [1] of this section.

B. Exemptions.

[1.] A health care provider is exempt from the requirement to submit medical bills electronically to a payer if:

[~~1.~~ a.] The health care provider employs [~~10~~ 15] or fewer full-time employees; [~~and~~ or]

[~~2. Treatment or services provided to injured workers to be billed under workers' compensation constitutes less than 10% of the health care provider's practice.~~ b. The health care provider submitted fewer than 250 medical bills for workers' compensation treatment, services, or products in the previous calendar year.

2. A payer is exempt from the requirements to receive and pay medical bills electronically if the payer processed fewer than 250 medical bills for workers' compensation treatment, services, or products in the previous calendar year.]

C. Complete electronic medical bill. To be considered a complete electronic medical bill, the bill or supporting transmissions shall:

1. Be submitted in the correct billing format;

2. Be transmitted in compliance with the format requirements described in 16VAC30-16-30;

3. Include in legible text all supporting documentation for the bill, including medical reports and records, evaluation reports, narrative reports, assessment reports, progress reports, progress notes, clinical notes, hospital records, and diagnostic test results that are expressly required by law or can reasonably be expected by the payer or its agent under the laws of Virginia;

4. Identify the following:

a. Injured employee;

b. Employer;

c. Insurance carrier, third-party administrator, managed care organization, or payer agent;

d. Health care provider;

e. Medical service or product; and

f. Any other requirements as presented in the Companion Guide; and

5. Use current and valid codes and values as defined in the applicable formats referenced in this chapter and the Companion Guide.

D. Acknowledgment.

1. An Interchange Acknowledgment (ASC X12 TA1) notifies the sender of the receipt of, and certain structural defects associated with, an incoming transaction.

2. An Implementation Acknowledgment (ASC X12 999) transaction is an electronic notification to the sender of the file that it has been received and has been:

a. Accepted as a complete and structurally correct file; or

b. Rejected with a valid rejection error code.

3. A Health Care Claim Acknowledgment (ASC X12 277CA) is an electronic acknowledgment to the sender of an electronic transaction that the transaction has been received and has been:

a. Accepted as a complete, correct submission; or

b. Rejected with a valid rejection error code.

4. A payer shall acknowledge receipt of an electronic medical bill by returning an Implementation Acknowledgment (ASC X12 999) within one business day of receipt of the electronic submission.

a. Notification of a rejected bill is transmitted using the appropriate acknowledgment when an electronic medical bill does not meet the definition of a complete electronic medical bill as described in subsection C of this section or does not meet the edits defined in the applicable implementation guide.

b. A health care provider or its agent shall not submit a duplicate electronic medical bill earlier than 60 calendar days from the date originally submitted if a payer has acknowledged acceptance of the original complete electronic medical bill. A health care provider or its agent may submit a corrected medical bill electronically to the

payer after receiving notification of a rejection. The corrected medical bill is submitted as a new, original bill.

5. A payer shall acknowledge receipt of an electronic medical bill by returning a Health Care Claim Acknowledgment (ASC X12 277CA) transaction (detail acknowledgment) within two business days of receipt of the electronic submission.

a. Notification of a rejected bill is transmitted in an ASC X12N 277CA response or acknowledgment when an electronic medical bill does not meet the definition of a complete electronic medical bill or does not meet the edits defined in the applicable implementation guide.

b. A health care provider or its agent shall not submit a duplicate electronic medical bill earlier than 60 calendar days from the date originally submitted if a payer has acknowledged acceptance of the original complete electronic medical bill. A health care provider or its agent may submit a corrected medical bill electronically to the payer after receiving notification of a rejection. The corrected medical bill is submitted as a new, original bill.

6. Acceptance of a complete medical bill is not an admission of liability by the payer. A payer may subsequently reject an accepted electronic medical bill if the employer or other responsible party named on the medical bill is not legally liable for its payment.

a. The rejection is transmitted by means of a Health Care Claim Payment/Advice ASC X12 835 transaction.

b. The subsequent rejection of a previously accepted electronic medical bill shall occur no later than 45 calendar days from the date of receipt of the complete electronic medical bill.

c. The transaction to reject the previously accepted complete medical bill shall clearly indicate that the reason for rejection is that the payer is not legally liable for its payment.

7. Acceptance of [~~an~~ a complete or] incomplete medical bill does not satisfy the written notice of injury requirement from an employee or payer as required by §§ 65.2-600 and 65.2-900 of the Code of Virginia.

[~~8. Acceptance of a complete or incomplete medical bill by a payer does begin the time period by which a payer shall accept or deny liability for any alleged claim related to such medical treatment pursuant to § 65.2-605.1 of the Code of Virginia.~~

~~9.~~ 8.] Transmission of an Implementation Acknowledgment under subdivision D 2 of this section and acceptance of a complete, structurally correct file serves as proof of the received date for an electronic medical bill in subsection C of this section.

E. Electronic documentation.

1. Electronic documentation, including medical reports and records submitted electronically that support an electronic medical bill, may be required by the payer before payment may be remitted to the health care provider in accordance with this chapter.

2. Complete electronic documentation shall be submitted by secure fax, secure encrypted electronic mail, or in a secure electronic format as described in 16VAC30-16-30.

3. The electronic transmittal, by secure fax, secure encrypted electronic mail, or any other secure electronic format, shall prominently contain the following details on its cover sheet or first page of the transmittal:

a. The name of the injured employee;

b. Identification of the worker's employer, the employer's insurance carrier, or the third-party administrator or its agent handling the workers' compensation claim;

c. Identification of the health care provider billing for services to the injured worker, and where applicable, its agent;

d. Dates of service;

e. The workers' compensation claim number assigned by the payer if established by the payer; and

f. The unique attachment indicator number.

F. Electronic remittance advice and electronic funds transfer.

1. An electronic remittance advice (ERA) is an explanation of benefits (EOB) or explanation of review (EOR), submitted electronically, regarding payment or denial of a medical bill, recoupment request, or receipt of a refund.

2. The ERA shall contain the appropriate Claim Adjustment Group Codes, Claim Adjustment Reason Codes, and associated Remittance Advice Remark Codes as specified in the Code Value Usage in Health Care Claim Payments and Subsequent Claims Technical Report Type 2 (TR2) Workers' Compensation Code Usage Section and for pharmacy charges, the National Council for Prescription Drugs Program (NCPDP) Reject/Payment Codes, denoting the reason for payment, adjustment, or denial. Instructions for the use of the ERA and code sets are found in section 7.5 of the Companion Guide.

3. The ERA shall be sent before five business days of:

a. The expected date of receipt by the health care provider of payment from the payer, or

b. The date the bill was rejected by the payer.

4. All payments for services [that have been billed electronically in accordance with this chapter] are required

to be paid via electronic funds transfer unless an alternate [~~electronic~~] method is agreed upon by the payer and health care provider.

G. Requirements for health care providers exempted from electronic billing. Health care providers exempted from electronic medical billing pursuant to [~~subsection~~ subdivision] B [1] of this section shall submit paper medical bills for payment in the following formats as applicable:

1. On the current standard forms used by CMS, which are available online at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/index.html.

2. On the current NCPDP Workers' Compensation/Property and Casualty Universal Claim Form (WC/PC UCF), which are available online at http://www.ncpdp.org/Products/Universal-Claim-Forms.

3. On the current American Dental Association Claim Form, which is available online at https://www.ada.org/en/publications/cdt/ada-dental-claim-form.

All information submitted on required paper billing forms under this subsection shall be legible and accurately completed.

H. Resubmissions. A health care provider or its agent shall not submit a duplicate paper medical bill earlier than 30 business days from the date originally submitted unless the payer has rejected the medical bill as incomplete in accordance with 16VAC30-16-60. A health care provider or its agent may submit a corrected paper medical bill to the payer after receiving notification of the rejection of an incomplete medical bill. The corrected medical bill is submitted as a new, original bill.

I. Connectivity. Unless the payer or its agent is exempted from the electronic medical billing process in accordance with [~~subsection~~ subdivision] B [2] of this section, it should attempt to establish connectivity through a trading partner agreement with any clearinghouse that requests the exchange of data in accordance with 16VAC30-16-30.

J. Fees. No party to the electronic transactions shall charge excessive fees of any other party in the transaction. A payer or clearinghouse that requests another payer or clearinghouse to receive, process, or transmit a standard transaction shall not charge fees or costs in excess of the fees or costs for normal telecommunications that the requesting entity incurs when it directly transmits or receives a standard transaction.

K. A health care provider agent may charge reasonable fees related to data translation, data mapping, and similar data functions when the health care provider is not capable of submitting a standard transaction. In addition, a health care provider agent may charge a reasonable fee related to:

1. Transaction management of standard transactions, such as editing, validation, transaction tracking, management reports, portal services, and connectivity; and

2. Other value added services, such as electronic file transfers related to medical documentation.

L. A payer or its agent shall not reject a standard electronic transaction on the basis that it contains data elements not needed or used by the payer or its agent or that the electronic transaction includes data elements that exceed those required for a complete bill as enumerated in subsection C of this section.

M. A health care provider that has not implemented a software system capable of sending standard transactions is required to use a secure online direct data entry system offered by a payer if the payer does not charge a transaction fee. A health care provider using an online direct data entry system offered by a payer or other entity shall use the appropriate data content and data condition requirements of the standard transactions.

16VAC30-16-60. Employer, insurance carrier, managed care organization, or agent's receipt of medical bills from health care providers.

A. Upon receipt of medical bills submitted in accordance with 16VAC30-16-30, 16VAC30-16-40, and 16VAC30-16-50, a payer shall evaluate each bill's conformance with the criteria of a complete electronic medical bill.

1. A payer shall not reject medical bills that are complete, unless the bill is a duplicate bill. [A payer may subsequently reject a complete medical bill or any portion thereof that is contested or denied in accordance with the requirements of subsection B of § 65.2-605.1 of the Code of Virginia.]

2. Within [~~21~~ 45] calendar days of receipt of an incomplete medical bill, a payer or its agent shall either:

a. Complete the bill by adding missing health care provider identification or demographic information already known to the payer; or

b. Reject the incomplete bill, in accordance with this subsection [and the requirements of subsection B of § 65.2-605.1 of the Code of Virginia].

B. The received date of an electronic medical bill is the date all of the contents of a complete electronic medical bill are successfully received by the payer.

C. The payer may contact the health care provider to obtain the information necessary to make the bill complete.

1. Any request by the payer or its agent for additional documentation to pay a medical bill shall:

a. Be made by telephone or electronic transmission unless the information cannot be sent by those media, in

which case the sender shall send the information by mail or personal delivery;

b. Be specific to the bill or the bill's related episode of care;

c. Describe with specificity the clinical and other information to be included in the response;

d. Be relevant and necessary for the resolution of the bill;

e. Be for information that is contained in or is in the process of being incorporated into the injured employee's medical or billing record maintained by the health care provider; and

f. Indicate the specific reason for which the insurance carrier is requesting the information.

2. If the payer or its agent obtains the missing information and completes the bill to the point that it can be adjudicated for payment, the payer shall document the name and telephone number of the person who supplied the information.

3. Health care providers and payers, or their agents, shall maintain documentation of any pertinent internal or external communications that are necessary to make the medical bill complete.

D. A payer shall not reject or deny a medical bill except as provided in subsection A of this section. When rejecting or denying an electronic medical bill, the payer shall clearly identify the reasons for the bill's rejection or denial by utilizing the appropriate codes in the standard transactions found in 16VAC30-16-50 D 3 b [and shall comply with all requirements of subsection B of § 65.2-605.1 of the Code of Virginia].

E. The rejection of an incomplete medical bill in accordance with this section fulfills the obligation of the payer to provide to the health care provider or its agent information related to the incompleteness of the bill.

F. Payers shall timely reject incomplete bills or request additional information needed to reasonably determine the amount payable.

1. For bills submitted electronically, the rejection of the entire bill or the rejection of specific service lines included in the initial bill shall be sent to the submitter [~~within two business days of receipt~~ as soon as practicable but not more than 45 calendar days after receipt].

2. If bills are submitted in a batch transmission, only the specific bills failing edits shall be rejected.

3. If there is a technical defect within the transmission itself that prevents the bills from being accessed or processed, the transmission will be rejected with an Interchange Acknowledgment (ASC X12 TA1) transaction or an Implementation Acknowledgment (ASC X12 999) transaction, as appropriate.

G. If a payer has reason to challenge the coverage or amount of a specific line item on a bill but has no reasonable basis for objections to the remainder of the bill, the uncontested portion shall be paid timely, as described in subsection H of this section.

H. Payment of all uncontested portions of a complete medical bill shall be made within 60 calendar days of receipt of the original bill or receipt of additional information requested by the payer allowed under the law. Amounts paid after this 60-calendar-day review period will accrue interest at the judgment rate of interest as provided in § 6.2-302 of the Code of Virginia. The interest payment shall be made at the same time.

[~~I. A payer shall not reject or deny a medical bill except as provided in subsection A of this section. When rejecting or denying a medical bill, the payer shall also communicate to the health care provider the reasons for the medical bill's rejection or denial.~~]

16VAC30-16-70. Communication between health care providers and payers.

A. Any communication between the health care provider and the payer related to medical bill processing shall be of sufficient specific detail to allow the responder to easily identify the information required to resolve the issue or question related to the medical bill. Generic statements that simply state a conclusion such as "payer improperly reduced the bill" or "health care provider did not document" or other similar phrases with no further description of the factual basis for the sender's position do not satisfy the requirements of this section.

B. The payer's utilization of the Claim Adjustment Group Codes, Claim Adjustment Reason Codes, or the Remittance Advice Remark Codes, or as appropriate, the National Council for Prescription Drugs Program Reject/Payment Codes, when communicating with the health care provider or its agent or assignee, through the use of the Health Care Claim Payment/Advice ASC X12 835 transaction, provides a standard mechanism to communicate issues associated with the medical bill.

C. Communication between the health care provider and payer related to medical bill processing shall be made by telephone or electronic transmission unless the information cannot be sent by those media, in which case the sender shall send the information by mail or personal delivery.

16VAC30-16-80. Medical documentation necessary for billing adjudication.

A. Medical documentation includes all medical reports and records permitted or required in accordance with Rule 4.2 of

the Rules of the Virginia Workers' Compensation Commission, subdivision 2 of 16VAC30-50-50.

B. Any request by the payer for additional documentation to process a medical bill shall conform to the requirements of 16VAC30-16-60 C.

C. It is the obligation of an insurer or employer to furnish its agents with any documentation necessary for the resolution of a medical bill.

D. Health care providers, health care facilities, third-party biller, third-party assignees, and claims administrators and their agents shall comply with all applicable federal and jurisdictional rules related to privacy, confidentiality, and security.

DOCUMENTS INCORPORATED BY REFERENCE (16VAC30-16)

Electronic Billing and Payment Companion Guide, Virginia Workers' Compensation Commission Release 1.0, 12/2018

VA.R. Doc. No. R16-4654; Filed December 20, 2018, 7:30 a.m.

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARD OF FUNERAL DIRECTORS AND EMBALMERS

Fast-Track Regulation

Title of Regulation: **18VAC65-20. Regulations of the Board of Funeral Directors and Embalmers (adding 18VAC65-20-236).**

Statutory Authority: §§ 54.1-2400 and 54.1-2805 of the Code of Virginia.

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: February 6, 2019.

Effective Date: February 21, 2019.

Agency Contact: Corie Tillman Wolf, Executive Director, Board of Funeral Directors and Embalmers, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4479, FAX (804) 527-4471, or email fanbd@dhp.virginia.gov.

Basis: Regulations are promulgated under the general authority of§ 54.1-2400 of the Code of Virginia, which provides the Board of Funeral Directors and Embalmers the authority to promulgate regulations to administer the regulatory system. Section 54.1-2805 of the Code of Virginia authorizes the board to promulgate regulations allowing students to assist with embalming in funeral establishments.

Purpose: The purpose of the amended regulation is compliance with the legislation passed by the General Assembly authorizing mortuary school students to assist with embalming in licensed funeral establishments in accordance with regulations promulgated by the board. The regulations are necessary to ensure a safe environment for such training, appropriate instruction in embalming, and awareness by consumers that training is occurring is the establishment. Regulations will protect not only the students and instructors but will further protect the safety and welfare of the public by having future licensees become more proficient embalmers.

Rationale for Using Fast-Track Rulemaking Process: Legislation passed by the General Assembly authorizes "a person who is duly enrolled in a mortuary education program in the Commonwealth may assist in embalming while under the immediate supervision of a funeral service licensee or embalmer with an active, unrestricted license issued by the Board, provided that such embalming occurs in a funeral service establishment licensed by the Board and in accordance with regulations promulgated by the Board." The regulations promulgated by the board are intended to facilitate such practice while protecting consumers of funeral services. They were developed in conjunction with the mortuary science programs, are consistent with their accrediting standards, and were unanimously adopted by the board. Therefore, the amendments should not be controversial.

Substance: To comply with the legislation of the 2018 General Assembly, regulations require (i) the establishment participating in training to have a current, unrestricted license and meet certain accreditation standards for training; (ii) specific instruction in embalming for students in the context of an embalming laboratory course; (iii) a limitation on the number of students who may be supervised and a requirement that the supervisor be physically present with the student who is assisting with embalming tasks; (iv) information on the embalming authorization form noting participation of students in the establishment; and (v) the name of the student and supervisor on the embalming report.

Issues: The advantage to the public is students who seek to become funeral service licensees will have a wider range of opportunities for embalming and training and will be more proficient after graduation. The mortuary school programs will see significant savings from a reduction in the number of cadavers they will need to purchase. There are no disadvantages for the public; there are adequate safeguards in the regulation to ensure an embalming with student assistance will be done properly under close supervision. There are no advantages or disadvantages to the agency or the Commonwealth.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. Pursuant to Chapter 186 of the 2018 Acts of Assembly,[1] the Board of Funeral Directors and Embalmers (Board) proposes to establish requirements for students assisting with embalming at licensed funeral establishments.

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

Estimated Economic Impact. Practical experience in embalming is a required part of obtaining a degree in mortuary science. Currently, such practical experience can only be obtained at the two mortuary education programs in the Commonwealth: John Tyler Community College and Tidewater Community College.

Chapter 186 established that "a person who is duly enrolled in a mortuary education program in the Commonwealth may assist in embalming while under the immediate supervision of a funeral service licensee or embalmer with an active, unrestricted license issued by the Board, provided that such embalming occurs in a funeral service establishment licensed by the Board and in accordance with regulations promulgated by the Board." In this action, the Board establishes rules by which this can happen.

This is beneficial in that it potentially provides the opportunity for mortuary students to have a greater range of experience in embalming, thus better preparing them to practice as a funeral service licensee. Also, according to the Department of Health Professions (DHP), the quality of available cadavers would typically be higher at funeral service establishments compared to those available to the community colleges.

Further, there may be significant cost savings to the mortuary school programs at the community colleges. One community college reported that it "will cut budget costs for the practical embalming component that is required by accrediting agency. Our program spends $2,100 per cadaver for the cadaver, transportation and cremation which equates to about $80,000 per academic year."[2] Through the enabling legislation and subsequent regulations, the program estimates that those costs will be cut in half.

Businesses and Entities Affected. According to DHP, there are 437 licensed funeral establishments that could potentially serve as a training site for student embalmers. All or most likely qualify as small businesses. There are two community colleges in the Commonwealth that have mortuary education programs.

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

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

Effects on the Use and Value of Private Property. The proposed amendments may result in mortuary students assisting in licensed mortuary establishments. The value of these private businesses is unlikely to be significantly affected.

Real Estate Development Costs. The proposed amendments do not affect real estate development costs.

Small Businesses:

Definition. Pursuant to § 2.2-4007.04 of the Code of Virginia, small business is defined as "a business entity, including its affiliates, that (i) is independently owned and operated and (ii) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million."

Costs and Other Effects. The proposed amendments do not significantly affect costs for small businesses.

Alternative Method that Minimizes Adverse Impact. The proposed amendments do not adversely affect small businesses.

Adverse Impacts:

Businesses. The proposed amendments do not adversely affect businesses.

Localities. The proposed amendments do not adversely affect localities.

Other Entities. The proposed amendments do not adversely affect other entities.

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[1]See http://leg1.state.va.us/cgi-bin/legp504.exe?181+ful+CHAP0186

[2]Source: Department of Health Professions

Agency's Response to Economic Impact Analysis: The Board of Funeral Directors and Embalmers concurs with the analysis of the Department of Planning and Budget.

Summary:

Pursuant to Chapter 186 of the 2018 Acts of Assembly, which allows a mortuary student to assist with embalming at a funeral establishment, the amendments require that (i) an establishment participating in student training has a current, unrestricted license and meets certain accreditation standards for training; (ii) students receive specific instruction in the context of an embalming laboratory course; (iii) a supervisor may supervise no more than three students and must be physically present when a student is assisting with embalming tasks; (iv) the embalming authorization form discloses the possible participation of students in embalming; and (v) the embalming report contains the name of the student and the signature of the supervisor if a student assisted in embalming.

18VAC65-20-236. Requirements for students assisting with embalming.

In accordance with § 54.1-2805 of the Code of Virginia, a student who is duly enrolled in a mortuary education program in the Commonwealth and who is not registered with the board as a funeral intern may assist in embalming in a funeral service establishment provided the following requirements are met:

1. The funeral establishment holds a current, unrestricted licensed issued by the board;

2.The funeral establishment and funeral service licensee or embalmer providing student supervision meet the accreditation standards of the American Board of Funeral Service Education and the Commission on Accreditation for off-campus embalming instruction;

3. Students shall receive instruction and shall observe embalming of a dead human body prior to assisting with an embalming in a funeral service establishment and shall assist with embalming in conjunction with an embalming laboratory course;

4. A funeral service licensee or embalmer may supervise up to three students under his immediate supervision, which shall mean the supervisor is physically and continuously present in the preparation room with the students to supervise each task to be performed;

5. A funeral service establishment shall include on the form granting permission to embalm information disclosing that the establishment is a training facility for mortuary education students and that a student may be assisting the licensee with embalming; and

6. The embalming report shall include the names of students assisting with an embalming and shall be signed by the supervisor.

VA.R. Doc. No. R19-5468; Filed December 12, 2018, 2:32 p.m.

BOARD OF NURSING

Fast-Track Regulation

Title of Regulation: **18VAC90-19. Regulations Governing the Practice of Nursing (amending 18VAC90-19-110).**

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

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: February 6, 2019.

Effective Date: February 21, 2019.

Agency Contact: Jay P. Douglas, R.N., Executive Director, Board of Nursing, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4520, FAX (804) 527-4455, or email jay.douglas@dhp.virginia.gov.

Basis: Regulations are promulgated under the general authority of § 54.1-2400 of the Code of Virginia, which provides the Board of Nursing the authority to promulgate regulations to administer the regulatory system, and § 54.1-3001 of the Code of Virginia, which provides the statutory authority for a 90-day period of practice following graduation from an approved nursing education program.

Purpose: The purpose is clarification of 18VAC90-19-110 F, which specifies the requirements for licensure by examination. As authorized by the Code of Virginia, the board allows an applicant to practice for 90 days following graduation from a nursing education program. The current language seems to indicate that the applicant has 90 days to practice following receipt of the authorization letter from the board. The board often encounters confusion among applicants about the timing of the 90 days of authorized practice. The amendment clarifies the use of titles by applicants, so employers and applicants will clearly understand the limitations. Public health and safety will be better protected by clarifying that applicants who have failed the examination or have not passed within the 90-day period cannot practice or represent themselves as registered nurse or licensed practical nurse applicants.

Rationale for Using Fast-Track Rulemaking Process: The action is intended to clarify the current regulation rather than change its substance. There should be no objection to making the rule clearer.

Substance: The board has amended 18VAC90-19-110 F to clarify that the use of titles by registered nurse and licensed practical nurse applicants is applicable only to those who have authorization to practice for 90 days following graduation from an approved nursing education program.

Issues: The primary advantage of the amendment to the public is clearer language to avoid confusion or possible unintentional violation of law and regulation. There are no disadvantages to the public. There are no advantages or disadvantages to the Commonwealth.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The Board of Nursing (Board) proposes to clarify that the designations "R.N. Applicant"[1] and "L.P.N. Applicant"[2] are applicable to authorized nurse licensure applicants for 90 days following graduation from an approved nursing education program, rather than 90 days following receipt of the authorization letter from the Board.

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

Estimated Economic Impact. Code of Virginia § 54.1-3001[3] authorizes the Board to allow a nursing applicant for licensure to practice for 90 days "following graduation from a nursing

education program." The current regulatory language implies that the applicant has 90 days to practice "following receipt of the authorization letter from the Board." According to the Department of Health Professions (DHP), the Board has often encountered confusion among applicants about the timing of the 90 days of authorized practice. The Board proposes to clarify the use of titles by applicants, so employers and applicants will clearly understand the limitations. Consequently, the proposed amendment would not affect requirements or opportunities but would be beneficial in that it may reduce confusion among the public and affected entities.

Businesses and Entities Affected. The proposed amendment affects nursing education graduates who wish to become authorized to practice prior to obtaining full licensure. According to DHP, the Board issues 50 to 100 authorization letters per week.

Localities Particularly Affected. The proposed amendment does not disproportionately affect particular localities.

Projected Impact on Employment. The proposed amendment does not significantly affect employment.

Effects on the Use and Value of Private Property. The proposed amendment does not affect the use and value of private property.

Real Estate Development Costs. The proposed amendment does not affect real estate development costs.

Small Businesses:

Definition. Pursuant to § 2.2-4007.04 of the Code of Virginia, small business is defined as "a business entity, including its affiliates, that (i) is independently owned and operated and (ii) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million."

Costs and Other Effects. The proposed amendment does not significantly affect costs for small businesses.

Alternative Method that Minimizes Adverse Impact. The proposed amendment does not adversely affect small businesses.

Adverse Impacts:

Businesses. The proposed amendment does not adversely affect businesses.

Localities. The proposed amendment does not adversely affect localities.

Other Entities. The proposed amendment does not adversely affect other entities.

[1]"R.N." is registered nurse.
[2]"L.P.N." is licensed practical nurse.
[3]See https://law.lis.virginia.gov/vacode/title54.1/chapter30/section54.1-3001/

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

Summary:

The amendment clarifies that the use of titles by registered nurse and licensed practical nurse applicants is applicable only to those who have authorization to practice for 90 days following graduation from an approved nursing education program.

Part III
Licensure and Renewal; Reinstatement

18VAC90-19-110. Licensure by examination.

A. The board shall authorize the administration of the NCLEX for registered nurse licensure and practical nurse licensure.

B. A candidate shall be eligible to take the NCLEX examination (i) upon receipt by the board of the completed application, the fee, and an official transcript or attestation of graduation from the nursing education program and (ii) when a determination has been made that no grounds exist upon which the board may deny licensure pursuant to § 54.1-3007 of the Code of Virginia.

C. To establish eligibility for licensure by examination, an applicant for the licensing examination shall:

1. File the required application, any necessary documentation and fee, including a criminal history background check as required by § 54.1-3005.1 of the Code of Virginia.

2. Arrange for the board to receive an official transcript from the nursing education program that shows either:

a. That the degree or diploma has been awarded and the date of graduation or conferral; or

b. That all requirements for awarding the degree or diploma have been met and that specifies the date of conferral.

3. File a new application and reapplication fee if:

a. The examination is not taken within 12 months of the date that the board determines the applicant to be eligible; or

b. Eligibility is not established within 12 months of the original filing date.

D. The minimum passing standard on the examination for registered nurse licensure and practical nurse licensure shall be determined by the board.

E. Any applicant suspected of giving or receiving unauthorized assistance during the examination may be noticed for a hearing pursuant to the provisions of the

Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia) to determine eligibility for licensure or reexamination.

F. Practice of nursing pending receipt of examination results.

1. A graduate who has filed a completed application for licensure in Virginia and has received an authorization letter issued by the board may practice nursing in Virginia from the date of the authorization letter. The period of practice shall not exceed 90 days between the date of successful completion of the nursing education program, as documented on the applicant's transcript, and the publication of the results of the candidate's first licensing examination.

2. Candidates who practice nursing as provided in subdivision 1 of this subsection shall use the designation "R.N. Applicant" or "L.P.N. Applicant" on a nametag or when signing official records.

3. The designations "R.N. Applicant" and "L.P.N. Applicant" shall not be used by applicants ~~who either do not take the examination within 90 days following receipt of the authorization letter from the board~~ beyond the 90-day period of authorized practice or by applicants who have failed the examination.

G. Applicants who fail the examination.

1. An applicant who fails the licensing examination shall not be licensed or be authorized to practice nursing in Virginia.

2. An applicant for licensure by reexamination shall file the required board application and reapplication fee in order to establish eligibility for reexamination.

3. Applicants who have failed the examination for licensure in another United States jurisdiction but satisfy the qualifications for licensure in this jurisdiction may apply for licensure by examination in Virginia. Such applicants shall submit the required application and fee. Such applicants shall not, however, be permitted to practice nursing in Virginia until the requisite license has been issued.

VA.R. Doc. No. R19-5478; Filed December 12, 2018, 2:33 p.m.

Fast-Track Regulation

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

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

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: February 6, 2019.

Effective Date: February 21, 2019.

Agency Contact: Jay P. Douglas, R.N., Executive Director, Board of Nursing, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4520, FAX (804) 527-4455, or email jay.douglas@dhp.virginia.gov.

Basis: Section 54.1-2400 of the Code of Virginia provides the Board of Nursing the authority to promulgate regulations to administer the regulatory system and to delegate to an agency subordinate the authority to conduct informal fact-finding proceedings.

Section 54.1-3408 of the Code of Virginia has numerous subsections authorizing unlicensed persons in certain settings to administer certain drugs, provided they have been properly trained. For example, subsection I states: "This section shall not prevent the administration of drugs by a person who has satisfactorily completed a training program for this purpose approved by the Board of Nursing…" To provide a regulatory structure for such training programs, the board promulgated 18VAC90-21. This chapter was carved out of 18VAC90-20 during the regulatory review of all regulations in 2014.

Likewise, subsection L of § 54.1-3408 provides: "A prescriber may authorize, pursuant to a protocol approved by the Board of Nursing the administration of vaccines to adults for immunization, when a practitioner with prescriptive authority is not physically present…." The protocol for such immunization is found in 18VAC90-21-50.

Purpose: The regulatory change is consistent with the principle of regulations that are clearly written and easily understandable. The current title of the regulation may be confusing to persons who think it applies to medication administration by licensed persons. It is necessary to retain the current chapter because its provisions protect the health and safety of the public, but the title is amended to be more descriptive of its content.

Rationale for Using Fast-Track Rulemaking Process: The Board of Nursing conducted a periodic review of 18VAC90-21. The amendment is technical in nature, does not change procedure, and has no impact on the public. Therefore, this action is not expected to be controversial.

Substance: The title is changed from Regulations for Medication Administration and Immunization Protocol to Regulations for Training Programs for Medication Administration by Unlicensed Persons and Immunization Protocol.

Issues: There are no advantages or disadvantages to the public; the amendment is technical and clarifying. There are no advantages or disadvantages to the agency or the Commonwealth.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The Board of Nursing (Board) proposes to amend the title of 18VAC90-21.

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

Estimated Economic Impact. The current title of 18VAC90-21 is Medication Administration Training and Immunization Protocol. The Board proposes to change the title to Training Programs for Medication Administration by Unlicensed Persons and Immunization Protocol. The Board believes that the current title of the regulation may be confusing to persons who think it applies to medication administration by licensed persons. The proposed amendment is moderately beneficial in that it may reduce potential confusion amongst the public. Since it has no associated cost, the proposal would produce a net benefit.

Businesses and Entities Affected. The proposed amendment affects members of the public who may misunderstand the application of the regulation.

Localities Particularly Affected. The proposed amendment does not disproportionately affect particular localities.

Projected Impact on Employment. The proposed amendment does not affect employment.

Effects on the Use and Value of Private Property. The proposed amendment does not affect the use and value of private property.

Real Estate Development Costs. The proposed amendment does not affect real estate development costs.

Small Businesses:

Definition. Pursuant to § 2.2-4007.04 of the Code of Virginia, small business is defined as "a business entity, including its affiliates, that (i) is independently owned and operated and (ii) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million."

Costs and Other Effects. The proposed amendment does not affect costs for small businesses.

Alternative Method that Minimizes Adverse Impact. The proposed amendment does not adversely affect small businesses.

Adverse Impacts:

Businesses. The proposed amendment does not adversely affect businesses.

Localities. The proposed amendment does not adversely affect localities.

Other Entities. The proposed amendment does not adversely affect other entities.

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

Summary:

The amendment modifies the chapter title to clarify that the regulations apply to medication administration by unlicensed persons.

CHAPTER 21
~~MEDICATION ADMINISTRATION~~ TRAINING PROGRAMS FOR MEDICATION ADMINISTRATION BY UNLICENSED PERSONS AND IMMUNIZATION PROTOCOL

VA.R. Doc. No. R19-5625; Filed December 12, 2018, 2:31 p.m.

Emergency Regulation

Titles of Regulations: **18VAC90-30. Regulations Governing the Licensure of Nurse Practitioners (amending 18VAC90-30-10, 18VAC90-30-20, 18VAC90-30-50, 18VAC90-30-85, 18VAC90-30-110, 18VAC90-30-120; adding 18VAC90-30-86).**

18VAC90-40. Regulations for Prescriptive Authority for Nurse Practitioners (amending 18VAC90-40-90).

Statutory Authority: §§ 54.1-2400 and 54.1-2957 of the Code of Virginia.

Effective Dates: January 7, 2019, through June 6, 2020.

Agency Contact: Jay P. Douglas, R.N., Executive Director, Board of Nursing, 9960 Mayland Drive, Suite 300, Richmond, VA 23233-1463, telephone (804) 367-4520, FAX (804) 527-4455, or email jay.douglas@dhp.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.

Chapter 776 of the 2018 Acts of Assembly permits a nurse practitioner who meets the statutory requirements to practice without a practice agreement with a patient care team physician and requires the Boards of Medicine and Nursing to jointly promulgate regulations to implement the act within 280 days of enactment.

The amendments set the qualifications for authorization for a nurse practitioner to practice without a practice agreement, including the hours required to be the equivalent of five years of full-time clinical experience, the

content of the attestation from the physician and the nurse practitioner, the submission of an attestation when the nurse practitioner is unable to obtain a physician attestation, the requirements for autonomous practice, and the fee for authorization for autonomous practice.

Part I
General Provisions

18VAC90-30-10. Definitions.

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

"Approved program" means a nurse practitioner education program that is accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs/Schools, American College of Nurse Midwives, Commission on Collegiate Nursing Education, or the National League for Nursing Accrediting Commission or is offered by a school of nursing or jointly offered by a school of medicine and a school of nursing that grant a graduate degree in nursing and ~~which~~ that hold a national accreditation acceptable to the boards.

"Autonomous practice" means practice in a category in which a nurse practitioner is certified and licensed without a written or electronic practice agreement with a patient care team physician in accordance with 18VAC90-30-86.

"Boards" means the Virginia Board of Nursing and the Virginia Board of Medicine.

"Certified nurse midwife" means an advanced practice registered nurse who is certified in the specialty of nurse midwifery and who is jointly licensed by the Boards of Medicine and Nursing as a nurse practitioner pursuant to § 54.1-2957 of the Code of Virginia.

"Certified registered nurse anesthetist" means an advanced practice registered nurse who is certified in the specialty of nurse anesthesia, who is jointly licensed by the Boards of Medicine and Nursing as a nurse practitioner pursuant to § 54.1-2957, and who practices under the supervision of a doctor of medicine, osteopathy, podiatry, or dentistry but is not subject to the practice agreement requirement described in § 54.1-2957.

"Collaboration" means the communication and decision-making process among members of a patient care team related to the treatment and care of a patient and includes (i) communication of data and information about the treatment and care of a patient, including exchange of clinical observations and assessments, and (ii) development of an appropriate plan of care, including decisions regarding the health care provided, accessing and assessment of appropriate additional resources or expertise, and arrangement of appropriate referrals, testing, or studies.

"Committee" means the Committee of the Joint Boards of Nursing and Medicine.

"Consultation" means the communicating of data and information, exchanging of clinical observations and assessments, accessing and assessing of additional resources and expertise, problem solving, and arranging for referrals, testing, or studies.

"Licensed nurse practitioner" means an advanced practice registered nurse who has met the requirements for licensure as stated in Part II (18VAC90-30-60 et seq.) of this chapter.

"National certifying body" means a national organization that is accredited by an accrediting agency recognized by the U.S. Department of Education or deemed acceptable by the National Council of State Boards of Nursing and has as one of its purposes the certification of nurse anesthetists, nurse midwives, or nurse practitioners, referred to in this chapter as professional certification, and whose certification of such persons by examination is accepted by the committee.

"Patient care team physician" means a person who holds an active, unrestricted license issued by the Virginia Board of Medicine to practice medicine or osteopathic medicine.

"Practice agreement" means a written or electronic statement, jointly developed by the collaborating patient care team ~~physician(s)~~ physician and the licensed nurse ~~practitioner(s)~~ practitioner that describes the procedures to be followed and the acts appropriate to the specialty practice area to be performed by the licensed nurse ~~practitioner(s)~~ practitioner in the care and management of patients. The practice agreement also describes the prescriptive authority of the nurse practitioner, if applicable. For a nurse practitioner licensed in the category of certified nurse midwife, the practice agreement is a statement jointly developed with the consulting physician.

18VAC90-30-20. Delegation of authority.

A. The boards hereby delegate to the executive director of the Virginia Board of Nursing the authority to issue the initial licensure and the biennial renewal of such licensure to those persons who meet the requirements set forth in this chapter, to grant authorization for autonomous practice to those persons who have met the qualifications of 18VAC90-30-86, and to grant extensions or exemptions for compliance with continuing competency requirements as set forth in subsection E of 18VAC90-30-105. Questions of eligibility shall be referred to the Committee of the Joint Boards of Nursing and Medicine.

B. All records and files related to the licensure of nurse practitioners shall be maintained in the office of the Virginia Board of Nursing.

18VAC90-30-50. Fees.

A. Fees required in connection with the licensure of nurse practitioners are:

1. Application	$125
2. Biennial licensure renewal	$80
3. Late renewal	$25
4. Reinstatement of licensure	$150
5. Verification of licensure to another jurisdiction	$35
6. Duplicate license	$15
7. Duplicate wall certificate	$25
8. Return check charge	$35
9. Reinstatement of suspended or revoked license	$200
10. Autonomous practice attestation	$100

B. For renewal of licensure from July 1, 2017, through June 30, 2019, the following fee shall be in effect:

Biennial renewal	$60

18VAC90-30-85. Qualifications for licensure by endorsement.

A. An applicant for licensure by endorsement as a nurse practitioner shall:

1. Provide verification of licensure as a nurse practitioner or advanced practice nurse in another U.S. jurisdiction with a license in good standing, or, if lapsed, eligible for reinstatement;

2. Submit evidence of professional certification that is consistent with the specialty area of the applicant's educational preparation issued by an agency accepted by the boards as identified in 18VAC90-30-90; and

3. Submit the required application and fee as prescribed in 18VAC90-30-50.

B. An applicant shall provide evidence that includes a transcript that shows successful completion of core coursework that prepares the applicant for licensure in the appropriate specialty.

C. An applicant for licensure by endorsement who is also seeking authorization for autonomous practice shall comply with subsection F of 18VAC90-30-86.

18VAC90-30-86. Autonomous practice for nurse practitioners other than certified nurse midwives or certified registered nurse anesthetists.

A. A nurse practitioner with a current, unrestricted license, other than someone licensed in the category of certified nurse midwife or certified registered nurse anesthetist, may qualify for autonomous practice by completion of the equivalent of five years of full-time clinical experience as a nurse practitioner.

1. Five years of full-time clinical experience shall be defined as 1,800 hours per year for a total of 9,000 hours.

2. Clinical experience shall be defined as the postgraduate delivery of health care directly to patients pursuant to a practice agreement with a patient care team physician.

B. Qualification for authorization for autonomous practice shall be determined upon submission of a fee as specified in 18VAC90-30-50 and an attestation acceptable to the boards. The attestation shall be signed by the nurse practitioner and the nurse practitioner's patient care team physician stating that:

1. The patient care team physician served as a patient care team physician on a patient care team with the nurse practitioner pursuant to a practice agreement meeting the requirements of this chapter and §§ 54.1-2957 and 54.1-2957.01 of the Code of Virginia;

2. While a party to such practice agreement, the patient care team physician routinely practiced with a patient population and in a practice area included within the category, as specified in 18VAC90-30-70, for which the nurse practitioner was certified and licensed; and

3. The period of time and hours of practice during which the patient care team physician practiced with the nurse practitioner under such a practice agreement.

C. The nurse practitioner may submit attestations from more than one patient care team physician with whom the nurse practitioner practiced during the equivalent of five years of practice, but all attestations shall be submitted to the boards at the same time.

D. If a nurse practitioner is licensed and certified in more than one category as specified in 18VAC90-30-70, a separate fee and attestation that meets the requirements of subsection B of this section shall be submitted for each category. If the hours of practice are applicable to the patient population and in practice areas included within each of the categories of licensure and certification, those hours may be counted toward a second attestation.

E. In the event a patient care team physician has died, become disabled, retired, or relocated to another state, or of other circumstance that inhibits the ability of the nurse practitioner from obtaining an attestation as specified in subsection B of this section, the nurse practitioner may submit other evidence of meeting the qualifications for autonomous practice along with an attestation signed by the nurse practitioner. Other evidence may include employment records, military service, Medicare or Medicaid reimbursement records, or other similar records that verify

full-time clinical practice in the role of a nurse practitioner in the category for which the nurse practitioner is licensed and certified. The burden shall be on the nurse practitioner to provide sufficient evidence to support the nurse practitioner's inability to obtain an attestation from a patient care team physician.

F. A nurse practitioner to whom a license is issued by endorsement may engage in autonomous practice if such application includes an attestation acceptable to the boards that the nurse practitioner has completed the equivalent of five years of full-time clinical experience as specified in subsection A of this section and in accordance with the laws of the state in which the nurse practitioner was previously licensed.

G. A nurse practitioner authorized to practice autonomously shall:

1. Only practice within the scope of the nurse practitioner's clinical and professional training and limits of the nurse practitioner's knowledge and experience and consistent with the applicable standards of care;

2. Consult and collaborate with other health care providers based on the clinical conditions of the patient to whom health care is provided; and

3. Establish a plan for referral of complex medical cases and emergencies to physicians or other appropriate health care providers.

18VAC90-30-110. Reinstatement of license.

A. A licensed nurse practitioner whose license has lapsed may be reinstated within one renewal period by payment of the current renewal fee and the late renewal fee.

B. An applicant for reinstatement of license lapsed for more than one renewal period shall:

1. File the required application and reinstatement fee;

2. Be currently licensed as a registered nurse in Virginia or hold a current multistate licensure privilege as a registered nurse; and

3. Provide evidence of current professional competency consisting of:

a. Current professional certification by the appropriate certifying agency identified in 18VAC90-30-90;

b. Continuing education hours taken during the period in which the license was lapsed, equal to the number required for licensure renewal during that period, not to exceed 120 hours; or

c. If applicable, current, unrestricted licensure or certification in another jurisdiction.

4. If qualified for autonomous practice, provide the required fee and attestation in accordance with 18VAC90-30-86.

C. An applicant for reinstatement of license following suspension or revocation shall:

1. Petition for reinstatement and pay the reinstatement fee;

2. Present evidence that he is currently licensed as a registered nurse in Virginia or hold a current multistate licensure privilege as a registered nurse; and

3. Present evidence that he is competent to resume practice as a licensed nurse practitioner in Virginia to include:

a. Current professional certification by the appropriate certifying agency identified in 18VAC90-30-90; or

b. Continuing education hours taken during the period in which the license was suspended or revoked, equal to the number required for licensure renewal during that period, not to exceed 120 hours.

The committee shall act on the petition pursuant to the Administrative Process Act, § 2.2-4000 et seq. of the Code of Virginia.

Part III
Practice of Licensed Nurse Practitioners

18VAC90-30-120. Practice of licensed nurse practitioners other than certified registered nurse anesthetists or certified nurse midwives.

A. A nurse practitioner licensed in a category other than certified registered nurse anesthetist or certified nurse midwife shall be authorized to render care in collaboration and consultation with a licensed patient care team physician as part of a patient care team or if determined by the boards to qualify in accordance with 18VAC90-30-86, authorized to practice autonomously without a practice agreement with a patient care team physician.

B. The practice shall be based on specialty education preparation as an advanced practice registered nurse in accordance with standards of the applicable certifying organization, as identified in 18VAC90-30-90.

C. All nurse practitioners licensed in any category other than certified registered nurse anesthetist or certified nurse midwife shall practice in accordance with a written or electronic practice agreement as defined in 18VAC90-30-10 or in accordance with 18VAC90-30-86.

D. The written or electronic practice agreement shall include provisions for:

1. The periodic review of patient charts or electronic patient records by a patient care team physician and may include provisions for visits to the site where health care is

delivered in the manner and at the frequency determined by the patient care team;

2. Appropriate physician input in complex clinical cases and patient emergencies and for referrals; and

3. The nurse practitioner's authority for signatures, certifications, stamps, verifications, affidavits, and endorsements provided it is:

a. In accordance with the specialty license of the nurse practitioner and within the scope of practice of the patient care team physician;

b. Permitted by § 54.1-2957.02 or applicable sections of the Code of Virginia; and

c. Not in conflict with federal law or regulation.

E. The practice agreement shall be maintained by the nurse practitioner and provided to the boards upon request. For nurse practitioners providing care to patients within a hospital or health care system, the practice agreement may be included as part of documents delineating the nurse practitioner's clinical privileges or the electronic or written delineation of duties and responsibilities; however, the nurse practitioner shall be responsible for providing a copy to the boards upon request.

Part III
Practice Requirements

18VAC90-40-90. Practice agreement.

A. With the ~~exception of~~ exceptions listed in subsection E of this section, a nurse practitioner with prescriptive authority may prescribe only within the scope of the written or electronic practice agreement with a patient care team physician.

B. At any time there are changes in the patient care team physician, authorization to prescribe, or scope of practice, the nurse practitioner shall revise the practice agreement and maintain the revised agreement.

C. The practice agreement shall contain the following:

1. A description of the prescriptive authority of the nurse practitioner within the scope allowed by law and the practice of the nurse practitioner.

2. An authorization for categories of drugs and devices within the requirements of § 54.1-2957.01 of the Code of Virginia.

3. The signature of the patient care team physician who is practicing with the nurse practitioner or a clear statement of the name of the patient care team physician who has entered into the practice agreement.

D. In accordance with § 54.1-2957.01 of the Code of Virginia, a physician shall not serve as a patient care team physician to more than six nurse practitioners with prescriptive authority at any one time.

E. Exceptions.

1. A nurse practitioner licensed in the category of certified nurse midwife and holding a license for prescriptive authority may prescribe in accordance with a written or electronic practice agreement with a consulting physician or may prescribe Schedule VI controlled substances without the requirement for inclusion of such prescriptive authority in a practice agreement.

2. A nurse practitioner who is licensed in a category other than certified nurse midwife or certified registered nurse anesthetist and who has met the qualifications for autonomous practice as set forth in 18VAC90-30-86 may prescribe without a practice agreement with a patient care team physician.

VA.R. Doc. No. R19-5512; Filed December 19, 2018, 9:45 a.m.

BOARD OF PHARMACY

Final Regulation

REGISTRAR'S NOTICE: The Board of Pharmacy is claiming an exemption from Article 2 of the Administrative Process Act in accordance with § 2.2-4006 A 13 of the Code of Virginia, which exempts amendments to regulations of the board to schedule a substance pursuant to subsection E of § 54.1-3443 of the Code of Virginia. The board will receive, consider, and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: **18VAC110-20. Regulations Governing the Practice of Pharmacy (amending 18VAC110-20-323).**

Statutory Authority: §§ 54.1-2400 and 54.1-3443 of the Code of Virginia.

Effective Date: February 6, 2019.

Agency Contact: Caroline Juran, RPh, Executive Director, Board of Pharmacy, 9960 Mayland Drive, Suite 300, Richmond, VA 23233-1463, telephone (804) 367-4456, FAX (804) 527-4472, or email caroline.juran@dhp.virginia.gov.

Summary:

The amendment adds one compound into Schedule V of the Drug Control Act pursuant to § 54.1-3443 E of the Code of Virginia to mirror a federal action, which does the same, and after the expiration of 30 days from publication in the Federal Register of the final federal rule.

18VAC110-20-323. Scheduling for conformity with federal law or rule.

Pursuant to subsection E of § 54.1-3443 of the Code of Virginia and in order to conform the Drug Control Act to

recent scheduling changes enacted in federal law or rule, the board:

1. Adds MT-45 (1-cyclohexyl-4-(1,2-diphenylethyl)piperazine) to Schedule I;

2. Adds Dronabinol ((-)-delta-9-trans tetrahydrocannabinol) in an oral solution in a drug product approved for marketing by the U.S. Food and Drug Administration to Schedule II; ~~and~~

3. Deletes naldemedine from Schedule II; and

4. Adds a drug product in finished dosage formulation that has been approved by the U.S. Food and Drug Administration that contains cannabidiol (2-[1R-3-methyl-6R-(1-methylethenyl)-2-cyclohexen-1-yl]-5-pentyl-1,3-benzenediol) derived from cannabis and no more than 0.1% (w/w) residual tetrahydrocannabinols to Schedule V.

VA.R. Doc. No. R19-5748; Filed December 12, 2018, 12:01 p.m.

BOARD OF SOCIAL WORK

Proposed Regulation

Title of Regulation: **18VAC140-20. Regulations Governing the Practice of Social Work (amending 18VAC140-20-105).**

Statutory Authority: §§ 54.1-2400 and 54.1-3708 of the Code of Virginia.

Public Hearing Information:

February 1, 2019 - 9:45 a.m. - Department of Health Professions, Perimeter Center, 9960 Mayland Drive, 2nd Floor, Richmond, VA 23233

Public Comment Deadline: March 8, 2019.

Agency Contact: Jaime Hoyle, Executive Director, Board of Social Work, 9960 Mayland Drive, Suite 300, Richmond, VA 23233-1463, telephone (804) 367-4406, FAX (804) 527-4435, or email jaime.hoyle@dhp.virginia.gov.

Basis: Section 54.1-2400 of the Code of Virginia provides the Board of Social Work the authority to promulgate regulations to administer the regulatory system. The board has a specific mandate to promulgate regulations requiring continuing education under § 54.1-3708 of the Code of Virginia.

Purpose: The purpose of adding required continuing education hours in ethics or standards of practice is to address a concern about complaints against social workers, almost all of which stem from an ethical issue or a failure to adhere to professional standards of practice. While the rate of complaints against clinical social workers is similar to or lower than other behavioral health professions (13.52 per 1,000 licensees for licensed clinical social workers (LCSWs); 15.75 per 1,000 for licensed professional counselors; and 16.45 per 1,000 for licensed clinical psychologists in the 2014-2016 biennium), the nature of the complaints indicates a lack of understanding of ethics or standards of practice. Therefore, the board believes a higher percentage of the total hours of continuing education should be devoted to those topics to protect the health, welfare, and safety of clients receiving social work services.

Substance: Currently, 18VAC140-20-105 specifies that 30 hours of continuing education are required for renewal of a licensed clinical social work license and 15 hours for a licensed social worker every two years. A minimum of two of those hours must pertain to ethics or the standards of practice for the behavioral health professions or to laws governing the practice of social work in Virginia. The proposed amendment would increase the ethics or standards requirement from two to six hours for LCSWs and three hours for licensed social workers; there would be no change in the total hours required.

Issues: The primary advantage to the public is some assurance that social workers are more knowledgeable about the ethics and standards of practice affecting their profession. There are no disadvantages to the public. There are no advantages and disadvantages to the agency or the Commonwealth.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The Board of Social Work (Board) proposes to reallocate continuing education (CE) hours to the required ethics or standards of practice for the behavioral health professions or the laws governing the practice of social work (ethics) for Licensed Clinical Social Workers (LCSWs) and Licensed Social Workers (LSWs).

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

Estimated Economic Impact. Currently, LCSWs must devote a minimum of two hours to ethics every two years out of the total 30 hours of CE required for renewal of a license. Similarly, LSWs are required to devote a minimum of two hours every two years for ethics out of the total 15 hours of CE.

The Board proposes to increase the hours for ethics from two to six hours for LCSWs and from two to three hours for LSWs with no change to the total CE hours required for either profession. According to the Board, the purpose of adding hours in ethics is to address a concern about complaints against social workers, almost all of which stem from an ethical issue or a failure to adhere to professional standards of practice. According to the Department of Health Professions (DHP), while the rate of complaints against LCSWs is similar to or lower than other behavioral health professions (13.52 per 1,000 licensees for LCSWs; 15.75 per 1,000 for licensed professional counselors; 16.45 per 1,000 for licensed clinical psychologists in the 2014-2016 biennium), the nature of the complaints indicates a lack of

understanding of ethics or standards of practice. Therefore, the Board believes a higher percentage of the total hours of continuing education should be devoted to those topics in order to protect the health, welfare and safety of clients receiving social work services.

Because there would be no change to the total continuing education hours required, the proposed change should not have any significant economic impact on licensees. However, the proposed change may necessitate an adjustment in continuing education provider curriculum and may add to their costs by a small amount. Since the number of current complaints received by the Board is likely to decrease with implementation of the proposed change, the regulatory package would likely produce a net benefit.

Businesses and Entities Affected. There are 6,985 licensed clinical social workers and 795 licensed social workers. DHP does not track the number of continuing education providers.

Localities Particularly Affected. The proposed regulation does not affect any particular locality more than others.

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

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

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

Small Businesses:

Definition. Pursuant to § 2.2-4007.04 of the Code of Virginia, small business is defined as "a business entity, including its affiliates, that (i) is independently owned and operated and (ii) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million."

Costs and Other Effects. Most continuing education providers are likely small businesses. However, having to adjust their curriculum to emphasize ethics/standards issues is not anticipated to have significant costs and other effects on them.

Alternative Method that Minimizes Adverse Impact. The proposed amendments would not have a significant adverse effect on continuing education providers.

Adverse Impacts:

Businesses. The proposed amendments would not adversely affect businesses.

Localities. The proposed amendments would not adversely affect localities.

Other Entities. The proposed amendments would not adversely affect other entities.

Agency's Response to Economic Impact Analysis: The Board of Social Work concurs with the analysis of the Department of Planning and Budget.

Summary:

The amendments increase the continuing education hours required for license renewal pertaining to ethics or the standards of practice to a minimum of six hours every two years for licensed clinical social workers and a minimum of three hours every two years for licensed social workers.

18VAC140-20-105. Continued competency requirements for renewal of an active license.

A. Licensed clinical social workers shall be required to have completed a minimum of 30 contact hours of continuing education and licensed social workers shall be required to have completed a minimum of 15 contact hours of continuing education prior to licensure renewal in even years. Courses or activities shall be directly related to the practice of social work or another behavioral health field. A minimum of ~~two~~ six of those hours for licensed clinical social workers and a minimum of three of those hours for licensed social workers must pertain to ethics or the standards of practice for the behavioral health professions or to laws governing the practice of social work in Virginia. Up to two continuing education hours required for renewal may be satisfied through delivery of social work services, without compensation, to low-income individuals receiving health services through a local health department or a free clinic organized in whole or primarily for the delivery of those services, as verified by the department or clinic. Three hours of volunteer service is required for one hour of continuing education credit.

1. The board may grant an extension for good cause of up to one year for the completion of continuing education requirements upon written request from the licensee prior to the renewal date. Such extension shall not relieve the licensee of the continuing education requirement.

2. The board may grant an exemption for all or part of the continuing education requirements due to circumstances beyond the control of the licensee such as temporary disability, mandatory military service, or officially declared disasters upon written request from the licensee prior to the renewal date.

B. Hours may be obtained from a combination of board-approved activities in the following two categories:

1. Category I. Formally Organized Learning Activities. A minimum of 20 hours for licensed clinical social workers or 10 hours for licensed social workers shall be documented in this category, which shall include one or more of the following:

a. Regionally accredited university or college academic courses in a behavioral health discipline. A maximum of 15 hours will be accepted for each academic course.

b. Continuing education programs offered by universities or colleges accredited by the Council on Social Work Education.

c. Workshops, seminars, conferences, or courses in the behavioral health field offered by federal, state or local social service agencies, public school systems, or licensed health facilities and licensed hospitals.

d. Workshops, seminars, conferences, or courses in the behavioral health field offered by an individual or organization that has been certified or approved by one of the following:

(1) The Child Welfare League of America and its state and local affiliates.

(2) The National Association of Social Workers and its state and local affiliates.

(3) The National Association of Black Social Workers and its state and local affiliates.

(4) The Family Service Association of America and its state and local affiliates.

(5) The Clinical Social Work Association and its state and local affiliates.

(6) The Association of Social Work Boards.

(7) Any state social work board.

2. Category II. Individual Professional Activities. A maximum of 10 of the required 30 hours for licensed clinical social workers or a maximum of five of the required 15 hours for licensed social workers may be earned in this category, which shall include one or more of the following:

a. Participation in an Association of Social Work Boards item writing workshop. (Activity will count for a maximum of two hours.)

b. Publication of a professional social work-related book or initial ~~preparation/presentation~~ preparation or presentation of a social work-related course. (Activity will count for a maximum of 10 hours.)

c. Publication of a professional social work-related article or chapter of a book, or initial ~~preparation/presentation~~ preparation or presentation of a social work-related in-service training, seminar, or workshop. (Activity will count for a maximum of five hours.)

d. Provision of a continuing education program sponsored or approved by an organization listed under Category I. (Activity will count for a maximum of two hours and will only be accepted one time for any specific program.)

e. Field instruction of graduate students in a Council on Social Work Education-accredited school. (Activity will count for a maximum of two hours.)

f. Serving as an officer or committee member of one of the national professional social work associations listed under subdivision B 1 d of this section or as a member of a state social work licensing board. (Activity will count for a maximum of two hours.)

g. Attendance at formal staffings at federal, state, or local social service agencies, public school systems, or licensed health facilities and licensed hospitals. (Activity will count for a maximum of five hours.)

h. Individual or group study including listening to audio tapes, viewing video tapes, or reading~~,~~ professional books or articles. (Activity will count for a maximum of five hours.)

VA.R. Doc. No. R18-5436; Filed December 12, 2018, 2:25 p.m.

TITLE 22. SOCIAL SERVICES

DEPARTMENT FOR AGING AND REHABILITATIVE SERVICES

Final Regulation

Title of Regulation: **22VAC30-20. Provision of Vocational Rehabilitation Services (amending 22VAC30-20-90).**

Statutory Authority: §§ 51.5-118 and 51.5-131 of the Code of Virginia.

Effective Date: February 6, 2019.

Agency Contact: Leah Mills, Policy Analyst, Department for Aging and Rehabilitative Services, 8004 Franklin Farms Drive, Richmond, VA 23229, telephone (804) 662-7610, FAX (804) 662-7663, TTY (800) 464-9950, or email leah.mills@dars.virginia.gov.

Summary:

The amendment reduces the number of categories for order of selection from four to three by combining priority categories II and III. In the event that the Department for Aging and Rehabilitative Services cannot provide the full range of vocational rehabilitation services to all eligible individuals who apply for these services because of insufficient resources, an order of selection may be implemented to determine those persons to be provided services.

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

22VAC30-20-90. Order of selection for services.

A. In the event that the full range of vocational rehabilitation services cannot be provided to all eligible individuals who apply for services because of insufficient resources, an order of selection system may be implemented by the commissioner following consultation with the State Rehabilitation Council. The order of selection shall determine those persons to be provided services. It shall be the policy of the department to encourage referrals and applications of all persons with disabilities and, to the extent resources permit, provide services to all eligible persons.

The following order of selection is implemented when services cannot be provided to all eligible persons:

1. Persons eligible and presently receiving services under an individualized plan for employment;

2. Persons referred and needing diagnostic services to determine eligibility; and

3. Persons determined to be eligible for services, but not presently receiving services under an individualized plan for employment, shall be served according to the following order of priorities:

a. Priority I. An individual with a most significant disability in accordance with the definition in 22VAC30-20-10;

b. Priority II. An individual with a significant disability that results in a serious functional ~~limitations~~ limitation in ~~two~~ at least one functional ~~capacities~~ capacity; and

c. Priority III. ~~An individual with a significant disability that results in a serious functional limitation in one functional capacity; and~~

~~d. Priority IV.~~ Other persons determined to be disabled, in order of eligibility determination.

B. An order of selection shall not be based on any other factors, including (i) any duration of residency requirement, provided the individual is present in the state; (ii) type of disability; (iii) age, gender, race, color, or national origin; (iv) source of referral; (v) type of expected employment outcome; (vi) the need for specific services or anticipated cost of services required by the individual; or (vii) the income level of an individual or an individual's family.

C. In administering the order of selection, the department shall (i) implement the order of selection on a statewide basis; (ii) notify all eligible individuals of the priority categories in the order of selection, their assignment to a particular category and their right to appeal their category assignment; (iii) continue to provide all needed services to any eligible individual who has begun to receive services under an individualized plan for employment prior to the effective date of the order of selection, irrespective of the severity of the individual's disability; and (iv) ensure that its funding arrangements for providing services under the state plan, including third-party arrangements and awards under the establishment authority, are consistent with the order of selection. If any funding arrangements are inconsistent with the order of selection, the department shall renegotiate these funding arrangements so that they are consistent with the order of selection.

D. Consultation with the State Rehabilitation Council shall include (i) the need to establish an order of selection, including any reevaluation of the need; (ii) priority categories of the particular order of selection; (iii) criteria for determining individuals with the most significant disabilities; and (iv) administration of the order of selection.

VA.R. Doc. No. R17-4951; Filed December 13, 2018, 11:24 a.m.

Final Regulation

Title of Regulation: **22VAC30-80. Auxiliary Grants Program (amending 22VAC30-80-10, 22VAC30-80-20, 22VAC30-80-30, 22VAC30-80-45 through 22VAC30-80-70; adding 22VAC30-80-35).**

Statutory Authority: §§ 51.5-131 and 51.5-160 of the Code of Virginia.

Effective Date: February 6, 2019.

Agency Contact: Tishaun Harris-Ugworji, Program Consultant, Department for Aging and Rehabilitative Services, 8004 Franklin Farms Drive, Richmond, VA 23229, telephone (804) 662-7531, or email tishaun.harrisugworji@dars.virginia.gov.

Summary:

The amendments (i) add supportive housing, which is a new living arrangement that individuals who receive auxiliary grant payments may choose, as a third setting in which individuals may receive the auxiliary grant; (ii) define requirements to participate in the supportive housing setting; (iii) clarify providers' responsibilities for each setting; and (iv) update terminology and guidelines for the Auxiliary Grant Program.

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

22VAC30-80-10. Definitions.

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

"Adult foster care" or "AFC" means a locally optional program that provides room and board, supervision, and special services to an individual who has a physical or mental health need. Adult foster care may be provided for up to three individuals by any one provider who is approved by the local department of social services.

"Assisted living care" means a level of service provided by an assisted living facility for individuals who may have physical or mental impairments and require at least moderate assistance with 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" or "ALF" means [~~, as defined in § 63.2-100 of the Code of Virginia,~~] 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~~ Virginia 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 residing in an ALF, either directly or through contracted agents, is considered "general supervision and oversight."~~]

"Authorized payee" means the individual who may be a court-appointed conservator or guardian, a person with a valid power of attorney, or an authorized representative with the documented authority to accept funds on behalf of the individual. An authorized payee for the auxiliary grant shall not be (i) the licensee or (ii) the owner of, employee of, or an entity hired by or contracted by the ALF or AFC home.

"Authorized representative" means the person representing or standing in place of the individual receiving the auxiliary grant for the conduct of the auxiliary grant recipient's affairs (i.e., personal or business interests). "Authorized representative" may include a guardian, conservator, attorney-in-fact under durable power of attorney, trustee, or other person expressly named in writing by the individual as his agent. An authorized representative shall not be (i) the licensee or (ii) the owner of, employee of, or an entity hired by or contracted by the ALF ~~or,~~ AFC home, or a supportive housing provider unless the auxiliary grant recipient designates such a person to assist with financial management of his personal needs allowance as a choice of last resort because there is no other authorized representative willing or available to serve in this capacity.

"Auxiliary Grants Program" or [~~"AG Program"~~ "AG"] means a state and locally funded assistance program to supplement income of an individual receiving Supplemental Security Income (SSI) or adult who would be eligible for SSI except for excess income, who resides in an ALF ~~or in~~, an AFC home, or a supportive housing setting with an established rate. The total number of individuals within the Commonwealth of Virginia eligible to receive AG in a supportive housing setting shall not exceed the number designated in the signed agreement between the department and the Social Security Administration.

"Certification" means an official approval as designated on the form provided by the department and prepared by ~~the~~ an ALF or a supportive housing provider. Each ALF shall annually ~~certifying~~ certify that ~~the ALF~~ it has properly managed the personal funds and personal needs allowances of individuals residing in the ALF and is in compliance with program regulations and appropriate licensing regulations. Each supportive housing provider shall annually certify that it is in compliance with this chapter.

"Department" means the Department for Aging and Rehabilitative Services.

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

"Established rate" means the rate as set forth in the appropriation act or as set forth to meet federal maintenance of effort requirements.

"Licensee" means any person, association, partnership, corporation, limited liability company, or governmental unit to whom a license to operate an ALF is issued in accordance with ~~22VAC40-72~~ 22VAC40-73.

"Personal funds" means payments the individual receives, whether earned or unearned, including wages, pensions, Social Security benefits, and retirement benefits. "Personal funds" does not include the personal needs allowance.

"Personal needs allowance" means a portion of the AG payment that is reserved for meeting the individual's personal needs. The amount is established by the Virginia General Assembly.

"Personal toiletries" means hygiene items provided to the individual by the ALF or AFC home including deodorant,

razor, shaving cream, shampoo, soap, toothbrush, and toothpaste.

[~~"Program" means the Auxiliary Grant~~ AG ~~Program.~~]

"Provider" means an ALF that is licensed by the [Virginia] Department of Social Services or an AFC provider that is approved by a local department of social services or a supportive housing provider as defined in § 37.2-421.1 of the Code of Virginia.

"Provider agreement" means a ~~document~~ written agreement that ~~the ALF~~ [~~ALFs~~ ALF] and supportive housing providers must complete and submit to the department when requesting ~~to be approved for admitting~~ approval to admit individuals receiving AG.

"Qualified assessor" means an individual who is authorized by 22VAC30-110 to perform an assessment, reassessment, or change in level of care for an individual applying for AG or residing in an ALF or a supportive housing setting. For individuals receiving services from a community services board or behavioral health authority, a qualified assessor is an employee or designee of the community services board or behavioral health authority.

"Rate" means the established rate.

"Residential living care" means a level of service provided by an ALF for individuals who may have physical or mental impairments and require only minimal assistance with the activities of daily living. Included in this level of service are individuals who are dependent in medication administration as documented on the Uniform Assessment Instrument (UAI).

"Supportive housing" or "SH" means a residential setting with access to supportive services for an AG recipient in which tenancy as described in § 37.2-421.1 of the Code of Virginia is provided or facilitated by a provider licensed to provide mental health community support services, intensive community treatment, programs of assertive community treatment, supportive in-home services, or supervised living residential services that has entered into an agreement with the DBHDS pursuant to § 37.2-421.1 of the Code of Virginia.

"Third-party payment" means a payment made by a third party to an ALF ~~or~~, an AFC home, or supportive housing provider on behalf of an AG recipient for goods or services other than for food, shelter, or specific goods or services required to be provided by the ALF ~~or~~, an AFC home, or a supportive housing provider as a condition of participation in the ~~Auxiliary Grants~~ AG [~~Program~~] in accordance with 22VAC30-80-45.

"Uniform Assessment Instrument" or "UAI" means the department-designated assessment form. It is used to record assessment information for determining the level of service that is needed.

22VAC30-80-20. Assessment.

A. In order to receive payment from the [~~program~~ AG] for care in an ALF or [~~in~~ an] AFC home, an individual applying for AG shall have been assessed by a qualified assessor using the UAI in accordance with 22VAC30-110 and determined to need residential or assisted living care or AFC.

B. As a condition of eligibility for the [~~program~~ AG], a UAI shall be completed on an individual prior to admission, except for an emergency placement as documented and approved by a Virginia adult protective services worker; at least once annually; and whenever there is a significant change in the individual's level of care, and a determination is made that the individual needs residential or assisted living care in an ALF or AFC home.

C. The ALF or AFC provider is prohibited from charging a security deposit or any other form of compensation for providing a room and services to the individual. The collection or receipt of money, gift, donation or other consideration from or on behalf of an individual for any services provided is prohibited.

D. In order to receive payment from the AG [~~program~~] for care in the SH setting, an individual shall be evaluated by a qualified assessor in accordance with § 51.5-160 E of the Code of Virginia. Eligible individuals shall be notified of the SH setting option and the availability of approved SH providers at the time of their annual level of care assessment. The individual may select SH or ALF at any time after the first or any subsequent annual reassessment as long as the individual meets the criteria for residential or assisted living level of care and subject to the availability of the selected housing option.

22VAC30-80-30. Basic services in an assisted living facility or an adult foster care home.

A. The rate established under the [~~program~~ AG] for the ALF setting shall cover the following services:

1. Room and board.

a. A furnished room in accordance with ~~22VAC40-72-730~~ 22VAC40-73-750;

b. Housekeeping services based on the needs of the individual;

c. Meals and snacks provided in accordance with ~~22VAC40-72~~ 22VAC40-73-590, including~~, but not limited to~~ food service, nutrition, number and timing of meals, observance of religious dietary practices, special diets, menus for meals and snacks, and emergency food and water. A minimum of three well-balanced meals shall be provided each day. When a diet is prescribed for an individual by his physician, it shall be prepared and served according to the physician's orders. Basic and bedtime snacks shall be made available for all individuals desiring them and shall be listed on the daily menu. Unless otherwise ordered in writing by the

individual's physician, the daily menu, including snacks, for each individual shall meet the guidelines of the U.S. Department of Agriculture's Food ~~Guide Pyramid~~ guidance system or the dietary allowances of the Food and Nutritional Board of the National Academy of Sciences, taking into consideration the age, sex, and activity of the resident. Second servings shall be provided, if requested, at no additional charge. At least one meal each day shall include a hot main dish; and

d. Clean bed linens and towels as needed by the individual and at least once a week.

2. Maintenance and care.

a. Minimal assistance as defined in ~~22VAC40-72-10~~ 22VAC40-73-10 with personal hygiene including bathing, dressing, oral hygiene, hair grooming and shampooing, care of clothing, shaving, care of toenails and fingernails or arranging for such assistance if the resident's medical condition precludes facility from providing the service, arranging for haircuts as needed, and care of needs associated with menstruation or occasional bladder or bowel incontinence that occurs less than weekly;

b. Medication administration as required by licensing regulations including insulin injections;

c. Provision of personal toiletries including toilet paper;

d. Minimal assistance with the following:

(1) Care of personal possessions;

(2) Care of the personal needs allowance and personal funds if requested by the individual and provider policy allows this practice, and in compliance with ~~22VAC40-72-140~~ 22VAC40-73-80 and ~~22VAC40-72-150, Standards for Licensed Assisted Living Facilities~~ 22VAC40-73-90;

(3) Use of the telephone;

(4) Arranging nonmedical transportation;

(5) Obtaining necessary personal items and clothing;

(6) Making and keeping appointments; and

(7) Correspondence;

e. Securing health care and transportation when needed for medical treatment;

f. Providing social and recreational activities in accordance with ~~22VAC40-72-520~~ 22VAC40-73-520; and

g. General supervision for safety.

B. The AFC provider shall adhere to the standards in 22VAC30-120-40.

22VAC30-80-35. Basic services in supportive housing settings.

A. The rate established under the [~~program~~ AG] for SH, as defined in 22VAC30-80-10, shall cover a residential setting with access to SH services that include:

1. Development of individualized SH service plans;

2. Access to skills training;

3. Assistance with accessing available community-based services and supports;

4. Initial identification and ongoing review of the level of care needs; and

5. Ongoing monitoring of services described in the individual's individualized SH plan.

B. The residential setting covered under the [~~program~~ AG] for SH, as defined in 22VAC30-80-10, shall be the least restrictive and most integrated setting practicable for the individual and shall:

1. Comply with federal habitability standards;

2. Provide cooking and bathroom facilities in each unit;

3. Afford dignity and privacy to the individual; and

4. Include rights of tenancy pursuant to the Virginia Residential Landlord and Tenant Act (§ 55-248.2 et seq. of the Code of Virginia).

22VAC30-80-45. Conditions of participation in the program.

A. Provider agreement for ALF.

1. As a condition of participation in the [~~program~~ AG], the ALF provider is required to complete and submit to the department a signed provider agreement as stipulated ~~in subdivision 2 of this subsection~~ in this section. The agreement is to be submitted prior to the ALF accepting AG payment for qualified individuals. A copy of the ALF's current license must be submitted with the provider agreement.

2. The ALF provider shall agree to the following conditions in the provider agreement to participate in the [~~program~~ AG]:

a. Provide services in accordance with all laws, regulations, policies, and procedures that govern the provision of services in the facility;

b. Submit an annual certification form by October 1 of each year;

c. Care for individuals with AG in accordance with the requirements in this chapter at the current established rate;

d. Refrain from charging the individual, his family, or his authorized personal representative a security deposit or any other form of compensation as a condition of admission or continued stay in the facility;

e. Accept the established rate as payment in full for services rendered;

f. Account for the personal needs allowances in a separate bank account and apart from other facility funds and issue a statement to each individual regarding his account balance that includes any payments deposited or withdrawn during the previous calendar month;

g. Provide a 60-day written notice to the regional licensing office in the event of the facility's closure or ownership change;

h. Provide written notification of the date and place of an individual's discharge or the date of an individual's death to the local department of social services determining the individual's AG eligibility and to the qualified assessor within 10 days of the individual's discharge or death; and

i. Return to the local department of social services determining the individual's AG eligibility, all AG funds received after the death or discharge date of an individual in the facility.

B. As a condition of participation in the [~~program~~ AG], the AFC provider shall be approved by a local department of social services and comply with the requirements set forth in 22VAC30-120.

C. Provider agreement for SH.

1. As a condition of participating in the AG [~~program~~], the SH provider shall enter an agreement with DBHDS pursuant to § 37.2-421.1 of the Code of Virginia.

2. The SH provider shall submit a copy of the executed agreement and a copy of its current DBHDS license prior to the SH provider receiving payments from the AG [~~program~~] on behalf of qualified individuals.

3. The SH provider shall provide SH services for each individual in accordance with § 37.2-421.1 of the Code of Virginia and all other applicable laws, regulations, and policies and procedures.

~~C.~~ D. ALFs ~~and~~, AFC homes, or SH providers providing services to AG recipients may accept third-party payments made by persons or entities for the actual costs of goods or services that have been provided to the AG recipient. The department shall not include such payments as income for the purpose of determining eligibility for or calculating the amount of an AG provided that the payment is made:

1. Directly to the ALF ~~or~~, AFC home, or SH provider by the third party on behalf of the individual after the goods or services have been provided;

2. Voluntarily by the third party, and not in satisfaction of a condition of admission, continued stay, or provision of proper care and services, unless the AG recipient's physical needs exceed the services required to be provided by the ALF, AFC, or SH provider as a condition of participation in the ~~auxiliary grant program~~ AG; and

3. For specific goods or services provided to the individual other than food, shelter, or other specific goods or services required to be provided by the ALF ~~or~~, AFC home, or SH provider as a condition of participation in the AG [~~program~~].

~~D.~~ E. Third-party payments shall not be used to pay for a private room in an ALF or AFC home.

~~E.~~ F. ALFs ~~and~~, AFC homes, and SH providers shall document all third-party payments received on behalf of an individual, including the source, amount, and date of the payment, and the goods or services for which such payments were made. Documentation related to the third-party payments shall be provided to the department upon request.

~~F.~~ G. ALFs ~~and~~, AFC homes, and SH providers shall provide each AG recipient and his authorized representative with a written list of the goods and services that shall be covered by the AG as defined in this chapter, including a clear statement that the facility shall not charge an individual or the individual's family or authorized representative additional amounts for goods or services included on such list. This statement shall be signed by the AG recipient or authorized representative as acknowledgment of receipt and shall be made available to the department upon request.

22VAC30-80-50. Establishment of rate.

The established rate for individuals authorized to reside in an ALF ~~or in~~, an AFC, or a supportive housing setting is the established rate as set forth in the appropriation act or as set forth by changes in the federal maintenance of effort formula. The AG payment is determined by adding the rate plus the personal needs allowance minus the individual's countable income. The effective date is the date of the individual's approval for AG by the local department of social services.

22VAC30-80-60. Reimbursement.

A. Any payments contributed toward the cost of ~~care~~ basic services as defined in 22VAC30-80-30 and 22VAC30-80-35 pending AG eligibility determination shall be reimbursed to the individual or contributing party by the ALF ~~or~~, AFC, or SH provider once eligibility for AG is established and that payment received. The payment shall be made payable to the individual, who will then reimburse the ~~provider for care~~ appropriate providers for basic services. If the individual is not capable of managing his finances, his authorized representative or authorized payee is responsible for reimbursing the provider.

B. In the event an ALF is closed, the facility shall prorate the rate up to the date of the individual's discharge and return the balance of the AG to the local department of social services that determined the individual's eligibility for the AG. If the facility maintained the individual's personal needs allowance, the facility shall provide a final accounting of the individual's personal needs allowance account within 60 days of the individual's discharge. Verification of the accounting and of the reimbursement to the individual shall be sent to the case management agency responsible for the individual's annual reassessment. In the event of the individual's death, the provider shall give to the individual's ~~personal~~ authorized representative a final accounting of the individual's funds within 60 calendar days of the event. All AG funds received after the death or discharge date shall be returned to the local department of social services responsible for determining the individual's AG eligibility as soon as practicable.

C. Providers who do not comply with the requirements of this chapter may be subject to adverse action, which may include suspension of new AG ~~program~~ [~~Program~~] admissions or termination of provider agreements.

22VAC30-80-70. ~~ALF certification~~ Certification and record requirements.

A. ~~ALFs~~ ALF and SH providers shall submit to the department an annual certification form by October 1 of each year for the preceding state fiscal year. The certification shall include the following: (i) identifying information about the ~~ALF~~ provider, (ii) census information including a list of individuals who resided in the facility or SH setting and received AG during the reporting period, and (iii) personal needs allowance accounting information if such personal needs accounting information is required by the setting. If a provider fails to submit an annual certification form, the provider will not be authorized to accept additional individuals with AG.

B. All information reported by an ALF or SH provider on the certification form shall be subject to audit by the department. Financial information that is not reconcilable to the provider's general ledger or similar records could result in establishment of a liability to the provider. Records shall be retained for three years after the end of the reporting period or until audited by the department, whichever is first.

C. All records maintained by an AFC provider, as required by 22VAC30-120, shall be made available to the department or the approving local department of social services upon request. All records are subject to audit by the department. Financial information that is not reconcilable to the provider's records could result in establishment of a liability to the provider. Records shall be retained for three years after the end of the reporting period or until audited by the department, whichever is first.

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, 900 East Main Street, 11th Floor, Richmond, Virginia 23219.

FORMS (22VAC30-80)

~~Auxiliary Grant Program Provider Agreement, 032-02-0747-02-eng (rev. 6/13)~~

~~Auxiliary Grant Certification, 032-02-0747-06-eng (rev. 5/13)~~

Auxiliary Grant Provider Agreement, 032-02-0747-06-eng (rev. 7/2017)

Auxiliary Grant Certification, Reporting Period July 1, 2016, to June 30, 2017, 032-02-0745-10-eng (rev. 7/2017)

Statement of Virginia Residency and Intent to Remain in Virginia, 032-02-0749-00-eng (eff. 12/2012)

Auxiliary Grant Certification, Reporting Period April 1, 2017, to October 1, 2017, 032-15-0012-00-eng (eff. 2/2017)

VA.R. Doc. No. R17-4816; Filed December 13, 2018, 11:21 a.m.

STATE BOARD OF SOCIAL SERVICES

Emergency Regulation

Title of Regulation: **22VAC40-677. State Oversight of a Local Social Services Department that Fails to Provide Services (adding 22VAC40-677-10).**

Statutory Authority: §§ 63.2-217 and 63.2-408 of the Code of Virginia.

Effective Dates: December 17, 2018, through June 16, 2020.

Agency Contact: Karin Clark, Regulatory Coordinator, Department of Social Services, 801 East Main Street, Richmond, VA 23219, telephone (804) 726-7017, FAX (804) 726-7015, or email karin.clark@dss.virginia.gov.

Preamble:

Section 2.2-4011 A of the Code of Virginia states that "[r]egulations that an agency finds are necessitated by an emergency situation may be adopted upon consultation with the Attorney General, which approval shall be granted only after the agency has submitted a request stating in writing the nature of the emergency, and the necessity for such action shall be at the sole discretion of the Governor."

Localities in Virginia are charged with administering public assistance and social services specifically intended to protect the health, safety, and welfare of citizens.

Included in these services are critical safety-net programs, such as Medicaid, Supplemental Nutrition Assistance Program, and Temporary Assistance for Needy Families. In addition, localities administer programs, such as child protective services and foster care, that protect the safety and well-being of the Commonwealth's most vulnerable citizens.

In the event the locality fails, refuses, or is unable to provide these core services, the safety and well-being of individuals in need are seriously jeopardized. This emergency action provides the Commissioner of the Department of Social Services with regulatory authority to provide immediate direction and oversight to a local department of social services, with appropriate State Board of Social Services proceedings. While this direction and oversight is not expected to be a frequent need, should the situation arise, the commissioner would be able to provide the appropriate resources in a timely manner to assess and remedy the situation in the local department.

Promulgating this regulation through the standard, three-stage regulatory process would take, at a minimum, 18 months and likely longer. Because of the human risk involved in not providing timely direction and oversight in the described scenario, the agency believes an emergency situation exists.

CHAPTER 677
STATE OVERSIGHT OF A LOCAL SOCIAL SERVICES DEPARTMENT THAT FAILS TO PROVIDE SERVICES

22VAC40-677-10. State response to when a local department of social services fails to provide services.

A. Each county and city must provide public assistance and social services in accordance with the provisions of Subtitles II (§ 63.2-500 et seq.) and III (§ 63.2-900 et seq.) of Title 63.2 of the Code of Virginia. If any county or city, through its appropriate authorities or officers fails, refuses, or is unable to provide public assistance or social services in accordance with the Code of Virginia, and with appropriate proceedings by the Board of Social Services as directed by § 63.2-408 of the Code of Virginia, the Commissioner of the Department of Social Services shall have the authority to direct and oversee all programs set forth in Subtitles II and III for that particular county or city, including to provide for the payment of public assistance and expenditures for social services and administration.

B. The commissioner may also withhold from any county or city the entire reimbursement for administrative expenditures or any part thereof for the period of time such locality fails to operate public assistance programs or social service programs in accordance with state laws and regulations or fails to provide the necessary staff for the implementation of such programs.

C. The commissioner shall at the end of each month file with the State Comptroller and with the local governing body of such county or city a statement showing all disbursements and expenditures, including administrative expenditures, made for and on behalf of such county or city, and the State Comptroller shall from time to time as such funds become available deduct from funds appropriated by the Commonwealth, in excess of requirements of the Constitution of Virginia, for distribution to such county or city amounts required to reimburse the Commonwealth for expenditures incurred under the provisions of this section.

D. In consultation with the county or city, the commissioner shall develop a transition plan that sets the conditions under which the responsibility to direct and oversee the programs is transferred back to the county or city.

E. The commissioner shall report quarterly to the State Board of Social Services and to the local board of social services on the status of services and expenditures in the city or county as well as the progress toward developing and meeting the conditions of the transition plan.

VA.R. Doc. No. R19-5464; Filed December 17, 2018, 1:00 p.m.

EXECUTIVE ORDER NUMBER TWENTY-SIX (2018)

Declaration of a State of Emergency for the Commonwealth of Virginia Due to Winter Weather

Importance of the Issue

On this date December 8th, 2018, I declare that a state of emergency exists in the Commonwealth of Virginia based on the need to prepare and coordinate our response to winter weather forecast to begin affecting the Commonwealth on December 9, 2018. This storm may result in snow and ice accumulations, transportation issues, and power outages.

State action is required to protect the health and general welfare of Virginia residents. The anticipated effects of this situation constitute a disaster wherein human life and public and private property are, or are likely to be, imperiled, as described in § 44-146.16 of the Code of Virginia.

Therefore, by virtue of the authority vested in me by § 44-146.17 of the Code of Virginia, as Governor and as Director of Emergency Management, and by virtue of the authority vested in me by Article V, Section 7 of the Constitution of Virginia and by § 44-75.1 of the Code of Virginia, as Commander-in-Chief of the armed forces of the Commonwealth, and subject always to my continuing and ultimate authority and responsibility to act in such matters, I hereby proclaim a state of emergency exists. Accordingly, I direct state and local governments to render appropriate assistance to prepare for this event, to alleviate any conditions resulting from the situation, and to implement recovery and mitigation operations and activities so as to return impacted areas to pre-event conditions as much as possible.

In order to marshal all public resources and appropriate preparedness, response, and recovery measures to meet this threat and recover from its effects, and in accordance with my authority contained in § 44-146.17 of the Code of Virginia, I order the following:

A. Implementation of the Commonwealth of Virginia Emergency Operations Plan (COVEOP), as amended, by state agencies along with other appropriate state plans.

B. Activation of the Virginia Emergency Operations Center (VEOC) and the Virginia Emergency Support Team (VEST), as directed by the State Coordinator of Emergency Management, to coordinate the provision of assistance to local governments and emergency services assignments of other agencies as necessary and determined by the State Coordinator of Emergency Management and other agencies as appropriate.

C. Activation of the Virginia National Guard and the Virginia Defense Force to state active duty to assist in providing such aid. This shall include Virginia National Guard assistance to the Virginia Department of State Police to direct traffic, prevent looting, and perform such other law enforcement functions as the Superintendent of State Police (in consultation with the State Coordinator of Emergency Management, the Adjutant General, and the Secretary of Public Safety and Homeland Security) may find necessary. Pursuant to § 52-6 of the Code of Virginia, I authorize the Superintendent of the Department of State Police to appoint any and all such Virginia Army and Air National Guard personnel called to state active duty as additional police officers as deemed necessary. These police officers shall have the same powers and perform the same duties as the Virginia State Police officers appointed by the Superintendent. Any bonds and/or insurance required by § 52-7 of the Code of Virginia shall be provided for them at the expense of the Commonwealth. In all instances, members of the Virginia National Guard and Virginia Defense Force shall remain subject to military command as prescribed by § 44-78.1 of the Code of Virginia and are not subject to the civilian authorities of county or municipal governments.

D. Activation, implementation, and coordination of appropriate mutual aid agreements and compacts, including the Emergency Management Assistance Compact (EMAC), and the authorization of the State Coordinator of Emergency Management to enter into any other supplemental agreements, pursuant to §§ 44-146.17(5) and 44-146.28:1 of the Code of Virginia. The State Coordinator of Emergency Management is hereby designated as Virginia's authorized representative within the meaning of the Emergency Management Assistance Compact, § 44-146.28:1 of the Code of Virginia.

E. This Emergency Declaration implements limited relief from the provisions of 49 CFR §§ 390.23 and 395.3 for the purpose of providing direct relief or assistance as a result of this disaster.

F. Authorization of the Virginia Departments of State Police, Transportation, and Motor Vehicles to grant temporary overweight, over width, registration, license, or hours of service exemptions to all carriers transporting essential emergency relief supplies to, through and from any area of the Commonwealth. This authorization also applies to water, food, heating oil, motor fuels or propane, or agricultural products, agricultural supplies, livestock and poultry, livestock and poultry feed, forest products and salvaged wood, waste, and trees cut in preparation for the storm, or providing restoration of utilities (including but not limited to electricity, gas, phone, water, wastewater, and cable) or removal of waste to, through and from any area of the Commonwealth in order to support the disaster response and recovery, regardless of their point of origin or destination. Weight exemptions are not valid on posted structures for restricted weight.

Weight exemptions are also not valid on interstate highways unless there is an associated federal emergency declaration. The exemption shall not exceed the duration of the motor

carrier's or drivers direct assistance in providing emergency relief, or 30 days from the initial declaration of emergency, whichever is less.

1. All over width loads, up to a maximum of 12 feet, and over height loads up to a maximum of 14 feet must follow Virginia Department of Motor Vehicles hauling permit and safety guidelines.

2. In addition to described overweight/over width transportation privileges, carriers are also exempt from vehicle registration with the Department of Motor Vehicles. This includes vehicles en route and returning to their home base. The agencies cited in this provision shall communicate this information to all staff responsible for permit issuance and truck legalization enforcement.

G. Implementation and discontinuance of the transportation-related provisions authorized above shall be disseminated by the publication of administrative notice to all affected and interested parties. I hereby delegate to the Secretary of Public Safety and Homeland Security, after consultation with other affected Cabinet Secretaries, the authority to implement and disseminate this Order as set forth in § 2.2-104 of the Code of Virginia.

H. Authorization of the Commissioner of Agriculture and Consumer Services to grant a temporary waiver of the maximum vapor pressure prescribed in regulation 2VAC5-425 et seq., and to prescribe a vapor pressure limit the Commissioner deems reasonable. The temporary waiver shall remain in effect until emergency relief is no longer necessary, as determined by the Commissioner of Agriculture and Consumer Services.

I. Provision of appropriate assistance, including temporary assignments of non-essential state employees to the Adjunct Emergency Workforce, be rendered by state agencies to respond to this situation.

J. Authorization of appropriate oversight boards, commissions, and agencies to ease building code restrictions, permitting requirements, and to allow for emergency demolition, hazardous waste disposal, debris removal, emergency landfill sitting, and other operations and activities necessary to address immediate health and safety needs without regard to time-consuming procedures or formalities and without regard to application or permit fees or royalties. All appropriate executive branch agencies are to exercise discretion to the extent allowed by law to address any pending deadlines or expirations affected by or attributable to this emergency event.

K. Authorization for the heads of executive branch agencies, with the concurrence of their Cabinet Secretary, to act, when appropriate, on behalf of their regulatory boards to waive any state requirement or regulation where the federal government has waived the corresponding federal or state regulation based on the impact of events related to this situation.

L. Activation of the statutory provisions in § 59.1-525 et seq. of the Code of Virginia related to price gouging.

M. Authorization of a maximum of $500,000 in state sum sufficient funds for state and local government mission assignments authorized and coordinated through the Virginia Department of Emergency Management that are allowable as defined by The Stafford Act, 42 U.S.C. § 5121 et seq. This funding is also available for state response and recovery operations and incident documentation. Out of this state disaster sum sufficient, an amount estimated at $ 270,000 is authorized for the Department of Military Affairs for the state's portion of the eligible disaster-related costs incurred for salaries, travel, and meals during mission assignments authorized and coordinated through the Virginia Department of Emergency Management.

N. Authorization of an amount estimated at $500,000 for matching funds for the Individuals and Household Program, authorized by The Stafford Act 42 U.S.C. § 5121 et seq. (when presidentially authorized), to be paid from state funds.

O. Implementation by public agencies under my supervision and control of their emergency assignments as directed in the COVEOP without regard to normal procedures pertaining to performance of public work, entering into contracts, incurring of obligations or other logistical and support measures of the Emergency Services and Disaster Laws, as provided in § 44-146.28(b) of the Code of Virginia. Section 44-146.24 of the Code of Virginia also applies to the disaster activities of state agencies.

P. During this declared emergency, any person who holds a license, certificate, or other permit issued by any state or political subdivision thereof, evidencing the meeting of qualifications for professional, mechanical, or other skills, the person, without compensation other than reimbursement for actual and necessary expenses, may render aid involving that skill in the Commonwealth during this emergency. Such person shall not be liable for negligently causing the death of, or injury to, any person or for the loss of, or damage to, the property of any person resulting from such service as set forth in Code of Virginia § 44-146.23(C). Additionally, members and personnel of volunteer, professional, auxiliary, and reserve groups identified and tasked by the State Coordinator of Emergency Management for specific disaster-related mission assignments, as representatives of the Commonwealth engaged in emergency services activities within the meaning of the immunity provisions of § 44-146.23(A) of the Code of Virginia, shall not be liable for the death of, or any injury to, persons or damage to property as a result of such activities, as provided in § 44-146.23(A) of the Code of Virginia.

Q. Designation of physicians, nurses, and other licensed and non-licensed health care providers and other individuals, as well as hospitals, nursing facilities and other licensed and non-licensed health care organizations, political subdivisions

and other private entities by state agencies, including the Departments of Health, Behavioral Health and Developmental Services, Social Services, Emergency Management, Transportation, State Police, and Motor Vehicles, as representatives of the Commonwealth engaged in emergency services activities, at sites designated by the Commonwealth, within the meaning of the immunity provisions of § 44-146.23(A) of the Code of Virginia, in the performance of their disaster-related mission assignments.

R. As provided in § 44-146.23(F) of the Code of Virginia, no individual, corporation, partnership, association, cooperative, limited liability company, trust, joint venture, fraternal organization, religious organization, charitable organization, or any other legal or commercial entity and any successor, officer, director, representative, or agent thereof, who, without compensation other than reimbursement for actual and necessary expenses, provides services, goods, real or personal property, or facilities at the request and direction of the State Department of Emergency Management or a county or city employee whose responsibilities include emergency management shall be liable for the death of or injury to any person or for the loss of, or damage to, the property of any person where such death, injury, loss, or damage was proximately caused by the circumstances of the actual emergency or its subsequent conditions, or the circumstances of this emergency.

Upon my approval, the costs incurred by state agencies and other agents in performing mission assignments through the VEOC as defined herein and in § 44-146.28 of the Code of Virginia, other than costs defined in the paragraphs above pertaining to the Virginia National Guard and pertaining to the Virginia Defense Force, shall be paid from state funds.

Effective Date of this Executive Order

This Executive Order shall be effective December 7, 2018, and shall remain in full force and in effect until January 6, 2019, unless sooner amended or rescinded by further executive order. Termination of the Executive Order is not intended to terminate any federal type benefits granted or to be granted due to injury or death as a result of service under this Executive Order.

Given under my hand and under the Seal of the Commonwealth of Virginia, this 8th day of December, 2018.

/s/ Ralph S. Northam
Governor

BOARD FOR THE BLIND AND VISION IMPAIRED

Notice of Periodic Review and Small Business Impact Review

Pursuant to Executive Order 14 (2018) and §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, the Board for the Blind and Vision Impaired is conducting a periodic review and small business impact review of each of the regulations listed below. The review of each regulation will be guided by the principles in Executive Order 14 (as amended July 16, 2018).

22VAC45-12, Public Participation Guidelines

22VAC45-30, Regulations Governing the Sale and Distribution of Goods and Articles Made by Blind Persons

22VAC45-40, Rules and Regulations Governing Vending Facilities in Public Buildings

22VAC45-51, Regulations Governing Provision of Services in Vocational Rehabilitation

22VAC45-70, Provision of Services in Rehabilitation Teaching

22VAC45-80, Provision of Independent Living Rehabilitation Services

22VAC45-100, Regulations Governing Deaf-Blind Services

22VAC45-110, Regulations Governing Low Vision

The purpose of this review is to determine whether each regulation should be repealed, amended, or retained in its current form. Public comment is sought on the review of any issue relating to each regulation, including whether the regulation (i) is necessary for the protection of public health, safety, and welfare or for the economical performance of important governmental functions; (ii) minimizes the economic impact on small businesses in a manner consistent with the stated objectives of applicable law; and (iii) is clearly written and easily understandable.

The comment period begins January 7, 2019, and ends January 28, 2019.

Comments may be submitted online to the Virginia Regulatory Town Hall at http://www.townhall.virginia.gov/L/Forums.cfm. Comments may also be sent to Susan K. Davis, Regulatory Coordinator, Board for the Blind and Vision Impaired, 401 Azalea Avenue, Richmond, VA 23227, telephone (804) 371-3184, FAX (804) 371-3157, or email susan.davis@dbvi.virginia.gov.

Comments must include the commenter's name and address (physical or email) information in order to receive a response to the comment from the agency. Following the close of the public comment period, a report of both reviews will be posted on the Town Hall and a report of the small business impact review will be published in the Virginia Register of Regulations.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Notice of Intent to Amend the Virginia State Plan for Medical Assistance pursuant to § 1902(a)(13) of the Social Security Act (USC § 1396a(a)(13))

The Virginia Department of Medical Assistance Services (DMAS) hereby affords the public notice of its intention to amend the Virginia State Plan for Medical Assistance to provide for changes to the Methods and Standards for Establishing Payment Rates; Other Types of Care (12VAC30-80).

This notice is intended to satisfy the requirements of 42 CFR 447.205 and of § 1902(a)(13) of the Social Security Act, 42 USC § 1396a(a)(13). A copy of this notice is available for public review from Jimeequa Williams, Policy and Research Division, Department of Medical Assistance Services, 600 Broad Street, Suite 1300, Richmond, VA 23219, or via email at jimeequa.williams@dmas.virginia.gov.

This notice is available for public review on the Virginia Regulatory Town Hall at http://www.townhall.gov, on the General Notices page, found at https://townhall.virginia.gov/L/generalnotice.cfm.

The reimbursement changes affect Methods and Standards for Establishing Payment Rates; Other Types of Care (12VAC30-80). In 12VAC30-80-30, the agency's fee schedule is being updated on January 1, 2019, to include updated dental procedure codes.

There is no expected increase or decrease in aggregate annual expenditures.

Contact Information: Emily McClellan, Regulatory Manager, Division of Policy and Research, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-4300, FAX (804) 786-1680, TDD (800) 343-0634, or email emily.mcclellan@dmas.virginia.gov.

DEPARTMENT OF MOTOR VEHICLES

Notice of Periodic Review and Small Business Impact Review

Pursuant to Executive Order 14 (as amended July 16, 2018) and §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, the Department of Motor Vehicles is conducting a periodic review and small business impact review of **24VAC20-121, Virginia Driver Training Schools Regulations**. The review of this regulation will be guided by the principles in Executive Order 14 (as amended July 16, 2018).

The purpose of this review is to determine whether this regulation should be repealed, amended, or retained in its

current form. Public comment is sought on the review of any issue relating to this regulation, including whether the regulation (i) is necessary for the protection of public health, safety, and welfare or for the economical performance of important governmental functions; (ii) minimizes the economic impact on small businesses in a manner consistent with the stated objectives of applicable law; and (iii) is clearly written and easily understandable.

The regulations may be viewed on the LIS webpage at https://law.lis.virginia.gov/admincodeexpand/title24/agency20/chapter121.

The comment period begins January 7, 2019, and ends January 28, 2019.

Comments may be submitted online to the Virginia Regulatory Town Hall at http://www.townhall.virginia.gov/L/Forums.cfm. Comments may also be sent to Domica Winstead, Senior Policy Analyst, Department of Motor Vehicles, 2300 West Broad Street, Suite 724, Richmond, VA 23220, telephone (804) 367-1864, FAX (804) 367-4336, or email domica.winstead@dmv.virginia.gov.

Comments must include the commenter's name and address (physical or email) information in order to receive a response to the comment from the agency. Following the close of the public comment period, a report of both reviews will be posted on the Town Hall and a report of the small business impact review will be published in the Virginia Register of Regulations.

BOARD OF PHYSICAL THERAPY

Notice of Periodic Review and Small Business Impact Review

Pursuant to Executive Order 14 (as amended July 16, 2018) and §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, the Board of Physical Therapy is conducting a periodic review and small business impact review of **18VAC112-20, Regulations Governing the Practice of Physical Therapy**. The review of this regulation will be guided by the principles in Executive Order 14 (as amended July 16, 2018).

The purpose of this review is to determine whether this regulation should be repealed, amended, or retained in its current form. Public comment is sought on the review of any issue relating to this regulation, including whether the regulation (i) is necessary for the protection of public health, safety, and welfare or for the economical performance of important governmental functions; (ii) minimizes the economic impact on small businesses in a manner consistent with the stated objectives of applicable law; and (iii) is clearly written and easily understandable.

The comment period begins January 7, 2019, and ends February 6, 2019.

Comments may be submitted online to the Virginia Regulatory Town Hall at http://www.townhall.virginia.gov/L/Forums.cfm. Comments may also be sent to Elaine Yeatts, Agency Regulatory Coordinator, Department of Health Professions, 9960 Mayland Drive, Richmond VA 23233, telephone (804) 367-4688, FAX (804) 527-4434, or email elaine.yeatts@dhp.virginia.gov.

Comments must include the commenter's name and address (physical or email) information in order to receive a response to the comment from the agency. Following the close of the public comment period, a report of both reviews will be posted on the Town Hall and a report of the small business impact review will be published in the Virginia Register of Regulations.

VIRGINIA WASTE MANAGEMENT BOARD

Small Business Impact Review - Report of Findings

Pursuant to § 2.2-4007.1 of the Code of Virginia, the Department of Environmental Quality conducted a small business impact review of **9VAC20-110, Regulations Governing the Transportation of Hazardous Materials**, and determined that this regulation should be retained in its current form. The Department of Environmental Quality is publishing its report of findings dated November 26, 2018, to support this decision in accordance with § 2.2-4007.1 F of the Code of Virginia.

This regulation is needed to ensure that hazardous materials are transported safely.

No comments were received during the public comment period.

The regulation incorporates applicable Code of Federal Regulations (CFR) sections into the regulation. The complexity of the regulation is minimized since Virginia's regulation incorporates sections of the CFR by reference; thereby making the federal and state requirements identical. Section 10.1-1454 of the Code of Virginia states:

> Any person transporting hazardous materials in accordance with regulations promulgated under the laws of the United States, shall be deemed to have complied with the provisions of this article, except when such transportation is excluded from regulation under the laws or regulations of the United States.

The regulation has been written to maintain consistency with the federal regulatory requirements pertaining to the transportation of hazardous materials due to the requirements of § 10.1-1454 the Code of Virginia.

Small businesses are required to comply with federal requirements concerning the transportation of hazardous materials; therefore, the adoption of less stringent requirements for small businesses in this regulation to

minimize the economic impact of the regulation would not be consistent with federal and state law.

Contact Information: Melissa Porterfield, Office of Regulatory Affairs, Virginia Waste Management Board, P.O. Box 1105, Richmond, VA 23218, telephone (804) 698-4238, FAX (804) 698-4019, or email melissa.porterfield@deq.virginia.gov.

STATE WATER CONTROL BOARD

Proposed Enforcement Action for BVU Authority

An enforcement action has been proposed for the BVU Authority for violations of the State Water Control Law in the City of Bristol, Virginia and Washington County, Virginia. A description of the proposed action is available at the Department of Environmental Quality office named below or online at www.deq.virginia.gov. Ralph T. Hilt will accept comments by email at ralph.hilt@deq.virginia.gov, FAX at (276) 676-4899, or postal mail at Department of Environmental Quality, Southwest Regional Office, 355-A Deadmore Street, Abingdon, VA 24210, from January 8, 2019, to February 7, 2019.

Proposed Enforcement Action for Del Monte Fresh Production Inc.

An enforcement action has been proposed for Del Monte Fresh Production Inc. for violations of the State Water Control Law in Accomack County, Virginia. A description of the proposed action is available at the Department of Environmental Quality office named below or online at www.deq.virginia.gov. Russell Deppe will accept comments by email at russell.deppe@deq.virginia.gov, FAX at (757) 518-2009, or postal mail at Department of Environmental Quality, Tidewater Regional Office, 5636 Southern Boulevard, Virginia Beach, VA 23462, from January 7, 2019, to February 6, 2019.

Proposed Enforcement Action for Virginia-Carolina Farm Associates LLC

An enforcement action has been proposed for Virginia-Carolina Farm Associates LLC for violations of the State Water Control Law at the Crittenden Road Mine in Suffolk, Virginia. A description of the proposed action is available at the Department of Environmental Quality office named below or online at www.deq.virginia.gov. John Brandt will accept comments by email at john.brandt@deq.virginia.gov, FAX at (757) 518-2009, or postal mail at Department of Environmental Quality, Tidewater Regional Office, 5636 Southern Boulevard, Virginia Beach, VA 23462, from January 7, 2019, to February 6, 2019.

VIRGINIA CODE COMMISSION

Notice to State Agencies

Contact Information: *Mailing Address:* Virginia Code Commission, Pocahontas Building, 900 East Main Street, 8th Floor, Richmond, VA 23219; *Telephone:* (804) 698-1810; *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 https://commonwealthcalendar.virginia.gov.

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.