VIRGINIA REGISTER OF REGULATIONS

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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).

March 2019 through April 2020

Volume: Issue	Material Submitted By Noon*	Will Be Published On
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
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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
36:10	December 18, 2019	January 6, 2020
36:11	January 1, 2020	January 20, 2020
36:12	January 15, 2020	February 3, 2020
36:13	January 29, 2020	February 17, 2020
36:14	February 12. 2020	March 2, 2020
36:15	February 26, 2020	March 16, 2020
36:16	March 11, 2020	March 30, 2020
36:17	March 25, 2020	April 13, 2020

*Filing deadlines are Wednesdays unless otherwise specified.

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARD OF COUNSELING

Agency Decision

Title of Regulation: **18VAC115-20. Regulations Governing the Practice of Professional Counseling.**

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

Name of Petitioner: Willard Vaughn.

Nature of Petitioner's Request: To amend regulations for residents in counseling to prohibit promoting or advertising their services independently to solicit business from the public.

Agency Decision: Request denied.

Statement of Reason for Decision: At its meeting on February 8, 2019, the board discussed the request to amend regulations and all comment received. The board concurred with many of the comments in opposition and voted not to initiate rulemaking at this time. A letter was sent to the petitioner to inform him of the board's decision.

Agency Contact: Jaime Hoyle, Executive Director, Board of Counseling, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4406, or email jaime.hoyle@dhp.virginia.gov.

VA.R. Doc. No. R19-16; Filed February 12, 2019, 9:12 a.m.

Agency Decision

Title of Regulation: **18VAC115-50. Regulations Governing the Practice of Marriage and Family Therapy.**

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

Name of Petitioner: Jamie West.

Nature of Petitioner's Request: To count up to 600 hours of supervised experience in a Commission on Accreditation for Marriage and Family Therapy Education or a Council for Accreditation of Counseling and Related Educational Programs doctoral program toward hours of residency.

Agency Decision: Request granted.

Statement of Reason for Decision: At its meeting on February 8, 2019, the board discussed the request to amend regulations and all comment received. The board voted to submit a Notice of Intended Regulatory Action (NOIRA) to initiate rulemaking and receive further information and comment. Once the NOIRA is approved by the Governor, it will be published and a 30-day public comment period will be opened. The regulatory process typically takes 18 months to complete. The petitioner was advised to follow its progress on the Virginia Regulatory Town Hall at www.townhall.virginia.gov.

Agency Contact: Jaime Hoyle, Executive Director, Board of Counseling, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4406, or email jaime.hoyle@dhp.virginia.gov.

VA.R. Doc. No. R19-17; Filed February 12, 2019, 9:18 a.m.

TITLE 12. HEALTH

STATE BOARD OF HEALTH

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the State Board of Health intends to consider amending **12VAC5-230, State Medical Facilities Plan**. The purpose of the proposed action is to begin the process of fulfilling the statutory mandate for the State Medical Facilities Plan (SMFP) Task Force to complete a review to update or validate the certificate of public need (COPN) criteria in the SMFP at least every four years by updating standards to reflect current clinical application and technical capability. Any decision to issue a COPN must be consistent with the most recent applicable provisions of the SMFP, which is the regulation providing service or facility specific criteria for determining public need. In making a determination of need for a requested project, the State Health Commissioner must take into consideration each of eight statutory criteria for determining need, including consistency with the SMFP.

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

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

Public Comment Deadline: April 3, 2019.

Agency Contact: Erik Bodin, COPN Division Director, Virginia Department of Health, 9960 Mayland Drive, Suite 401, Richmond, VA 23233, telephone (804) 367-1889, FAX (804) 527-4502, or email erik.bodin@vdh.virginia.gov.

VA.R. Doc. No. R19-5768; Filed February 5, 2019, 3:57 p.m.

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARD OF FUNERAL DIRECTORS AND EMBALMERS

Withdrawal of Notice of Intended Regulatory Action

Notice is hereby given that the Board of Funeral Directors and Embalmers has WITHDRAWN the Notice of Intended Regulatory Action for **18VAC65-40, Regulations for the Funeral Service Internship Program,** which was published in 34:25 VA.R. 2489 August 6, 2018. The amendments intended for this action will be incorporated into an action resulting from the periodic review of 18VAC65-40. A new notice announcing an action including all amendments from the periodic review will be published at a later date.

Statutory Authority: §§ 54.1-2400 and 54.1-2817 of the Code of Virginia.

Agency Contact: Corie Tillman-Wolf, Executive Director, Board of Funeral Directors and Embalmers, 9960 Mayland Drive, Suite 300, Richmond, VA 23233-1463, telephone (804) 367-4424, FAX (804) 527-4637, or email corie.wolf@dhp.virginia.gov.

VA.R. Doc. No. R18-5595; Filed February 1, 2019, 4:24 p.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 repealing **22VAC40-191, Background Checks for Child Welfare Agencies**, and promulgating **22VAC40-192, Background Checks for Child Welfare Agencies**. The purpose of the proposed action is to repeal the existing regulation, 22VAC40-191, and replace it with a new regulation, 22VAC40-192, for consistency with federal law and the Code of Virginia. Repeal of the existing regulation and adoption of a new regulation allows greater flexibility to adjust the structure, format, and language of the regulation while incorporating state and federal requirements for background checks. Multiple changes are needed to update the existing regulation, including new requirements for fingerprint based background checks and out-of-state child abuse and neglect registry background checks, as well as correcting Code of Virginia citations that are no longer accurate. Several new sections will be added to provide program specific information. Other changes the agency deems necessary after comments and review may also be made.

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 63.2-1734 of the Code of Virginia.

Public Comment Deadline: April 3, 2019.

Agency Contact: Deborah Eves, Program Consultant, Department of Social Services, 801 East Main Street, Richmond, VA 23219, telephone (804) 726-7506, or email deborah.eves@dss.virginia.gov.

VA.R. Doc. No. R19-5557; Filed February 8, 2019, 8:49 a.m.

TITLE 3. ALCOHOLIC BEVERAGES

ALCOHOLIC BEVERAGE CONTROL AUTHORITY

Proposed Regulation

Title of Regulation: **3VAC5-70. Other Provisions (amending 3VAC5-70-210).**

Statutory Authority: §§ 4.1-111 and 4.1-227 of the Code of Virginia.

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: May 6, 2019.

Agency Contact: LaTonya D. Hucks-Watkins, Legal Liaison, Virginia Alcoholic Beverage Control Authority, 2901 Hermitage Road, Richmond, VA 23220, telephone (804) 213-4698, FAX (804) 213-4574, or email latonya.hucks-watkins@abc.virginia.gov.

Basis: Section 4.1-101 of the Code of Virginia establishes the Virginia Alcoholic Beverage Control Authority. Section 4.1-103 of the Code of Virginia enumerates the powers of the board of directors, which includes the authority to adopt regulations and to do all acts necessary or advisable to carry out the purposes of Title 4.1 of the Code of Virginia, including promulgate regulations in accordance with the Administrative Process Act and § 4.1-111 of the Code of Virginia. Section 4.1-227 of the Code of Virginia permits the board to impose and collect civil penalties.

Purpose: The purpose of the proposed amendments is to amend civil penalties for first-offense violations so that the new schedule of penalties will continue to encourage settlement for first-offense matters where there are no disputed facts and the licensee desires to resolve the matter without a hearing. The penalties remain lower than the maximum penalties listed in the Code of Virginia; however, there is a reasonable increase in previous amounts to reflect the increases in maximum civil penalties listed in § 4.1-227 of the Code of Virginia that were enacted in 2017. This action protects public health, safety, or welfare because increasing the penalties acts as a deterrent to licensees committing violations while still promoting education of the Alcoholic Beverage Control Act in exchange for a lower penalty and making the disciplinary process more efficient.

Substance: Any licensee charged with one of the offenses listed in 3VAC5-70-210, provided that the licensee has no other pending charges and has not had any substantiated violations of regulation or statute within the three years immediately preceding the date of the violation, may enter a written waiver of hearing and accept a period of suspension or pay a civil charge in lieu of a suspension. The amounts of the civil charges are listed in 3VAC5-70-210 and are less than the maximum monetary penalties permitted by § 4.1-227 of the Code of Virginia. The amendments increase the civil charges listed in 3VAC5-70-210 by either $250 or $500. The current civil charges are based on out-of-date maximum penalties that existed prior to the amendments in 2017.

Issues: The primary advantage to the public, that is, licensees, is that the regulation continues to function as a means to allow licensees to resolve low-level first offenses expeditiously through a process that resolves the matter without licensees having to go through the hearing process, which can oftentimes be intimidating and stressful. The "disadvantage" is that these new penalties are higher than the previous penalties, but the General Assembly has increased the statutory maximums, so these penalties should increase as well to maintain a degree of consequence.

The primary advantage to the agency is that the regulation continues to encourage prompt resolution for undisputed, low-level violations. This is very beneficial to the agency as a whole because since becoming an authority, the agency is operating with a part-time board of directors, and the more cases that are resolved through settlement, the less taxing it is on the board. There are no disadvantages to the agency.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. Following the 2017 legislative increase in maximum amount of penalties the Alcoholic Beverage Control Authority Board of Directors (Board) is authorized to impose,[1] the Board proposes to increase penalties for first-offense violations by either $250 or $500.

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

Estimated Economic Impact. The 2017 General Assembly increased the maximum penalty from $2,500 to $3,000 for first-offense violations involving sale of alcohol to persons prohibited from purchasing alcohol and from $1,000 to $2,000 for other first-offense violations.[2] Accordingly, the Board proposes to increase the 26 different civil charges prescribed in this regulation by either $250 or $500. Based on the type and number of violations that occurred in 2017, the Alcoholic Beverage Control Authority (ABC) expects the collections of penalties to increase from $532,225 to $794,250, a $262,025 annual increase. The money collected from penalties is a source of General Fund

revenue. Thus, the anticipated increase will be available to pay for general state expenditures.

In addition to the positive revenue impact, higher penalties would likely discourage violations and improve compliance. According to ABC, the Board opted not to increase the penalties to the maximum authorized in the legislation in order to encourage resolution of low-level first offenses expeditiously through a process without licensees having to go through the hearing process, which can oftentimes be intimidating and stressful.

Businesses and Entities Affected. The proposed new civil penalties apply to approximately 18,000 Board licensees. Most of the licensees are likely small businesses such as restaurants, bars, grocery stores, wineries, etc.

Localities Particularly Affected. The proposed changes would not disproportionately affect particular localities.

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

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

Real Estate Development Costs. The proposed changes would 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 changes would not have costs or other effects on small businesses licensees unless they commit a first-offense.

Alternative Method that Minimizes Adverse Impact. The proposed changes would not impose adverse impacts on small businesses unless they commit a first-offense. There is no known alternative to minimize the adverse impact on such businesses while accomplishing the same goals.

Adverse Impacts:

Businesses. The proposed changes would not impose adverse impacts on non-small business licensees unless they commit a first-offense.

Localities. The proposed changes would not adversely affect localities.

Other Entities. The proposed changes would not adversely affect other entities.

Agency's Response to Economic Impact Analysis: The Virginia Alcoholic Beverage Control Authority concurs with the Department of Planning and Budget's economic impact analysis.

Summary:

The proposed amendments increase the civil penalty amounts charged in lieu of suspension for first-offense violations for a licensee that has no other pending charges, has not had a violation in three years, and enters a written waiver of hearing. The proposed increases reflect maximums effective July 2017 in § 4.1-227 of the Code of Virginia.

3VAC5-70-210. Schedule of penalties for first-offense violations.

A. Any licensee charged with any violation of board regulations or statutes listed ~~below~~ in this subsection, if the licensee has no other pending charges and has not had any substantiated violations of regulation or statute within the three years immediately preceding the date of the violation, may enter a written waiver of hearing and (i) accept the period of license suspension set forth ~~below~~ in this subsection for the violation, or (ii) pay the civil charge set forth below for the violation in lieu of suspension. In the case of a violation involving the sale of beer, wine, or mixed beverages to a person at least 18 but ~~under~~ younger than 21 years of age, or to an intoxicated person, or allowing consumption of such beverages by such person, any retail licensee that can demonstrate that it provided alcohol ~~seller/server~~ seller or server training certified in advance by the board to the employee responsible for such violation within the 12 months immediately preceding the alleged violation may accept the lesser period of license suspension or pay the lesser civil charge listed ~~below~~ for the violation in lieu of suspension. Any notice of hearing served on a licensee for a violation covered by this section shall contain a notice of the licensee's options under this section. Any licensee who fails to notify the board of its intent to exercise one of the options provided for under this section within 20 days after the date of mailing of the notice of hearing shall be deemed to have waived the right to exercise such options, and the case shall proceed to hearing. For good cause shown, the board may, in its discretion, allow a licensee to exercise the options provided for under this section beyond the 20-day period.

[1]http://lis.virginia.gov/cgi-bin/legp604.exe?171+ful+CHAP0698
http://lis.virginia.gov/cgi-bin/legp604.exe?171+ful+CHAP0707

[2]Ibid.

VIOLATION	SUSPENSION	CIVIL CHARGE	SUSPENSION WITH CERTIFIED TRAINING	CIVIL CHARGE WITH CERTIFIED TRAINING
Sale of beer, wine, or mixed beverages to a person at least 18 but ~~under~~ younger than 21 years of age.	25 days	~~$2,000~~ $2,500	5 days	~~$1,000~~ $1,500
Allowing consumption of beer, wine, or mixed beverages by a person at least 18 but ~~under~~ younger than 21 years of age.	25 days	~~$2,000~~ $2,500	5 days	~~$1,000~~ $1,500
Aiding and abetting the purchase of alcoholic beverages by a person at least 18 but ~~under~~ younger than 21 years of age.	10 days	~~$1,000~~ $1,250		
Keeping unauthorized alcoholic beverages on the premises, upon which appropriate taxes have been paid.	7 days	~~$500~~ $750		
Allow an intoxicated person to loiter on the premises.	7 days	~~$500~~ $750		
Sale to an intoxicated person.	25 days	~~$2,000~~ $2,500	5 days	~~$1,000~~ $1,500
Allow consumption by an intoxicated person.	25 days	~~$2,000~~ $2,500	5 days	~~$1,000~~ $1,500
After hours sales or consumption of alcoholic beverages.	10 days	~~$1,000~~ $1,250		
No designated manager on premises.	7 days	~~$500~~ $750		
Invalid check to wholesaler or board.	7 days	~~$250~~ $500		
Inadequate illumination.	7 days	~~$500~~ $750		
ABC license not posted.	7 days	~~$500~~ $750		
Not timely submitting report required by statute or regulation.	7 days	~~$500~~ $750		

Designated manager not posted.	7 days	~~$500~~ $750		
Person ~~less~~ younger than 18 years of age serving alcoholic beverages; ~~less~~ younger than 21 years of age acting as bartender.	7 days	~~$500~~ $750		
Sale of alcoholic beverages in unauthorized place or manner.	10 days	~~$1,000~~ $1,250		
Consumption of alcoholic beverages in unauthorized area.	7 days	~~$500~~ $750		
Removal of alcoholic beverages from authorized area.	7 days	~~$500~~ $750		
Failure to obliterate mixed beverage stamps.	7 days	~~$500~~ $750		
Employee on duty consuming alcoholic beverages.	7 days	~~$500~~ $750		
Conducting illegal happy hour.	7 days	~~$500~~ $750		
Illegally advertising happy hour.	7 days	~~$500~~ $750		
Unauthorized advertising.	7 days	~~$500~~ $750		
Failure to remit state ~~beer/wine~~ beer or wine tax (if deficiency has been corrected).	10 days	~~$1,000~~ $1,250		
Wholesaler sale of ~~wine/beer~~ beer or wine in unauthorized manner.	10 days	~~$1,000~~ $1,250		
Wholesaler sale of ~~wine/beer~~ beer or wine to unauthorized person.	10 days	~~$1,000~~ $1,250		

B. For purposes of this section, the Virginia ~~Department of~~ Alcoholic Beverage Control Authority will certify alcohol ~~seller/server~~ seller or server training courses that provide instruction on all the topics listed on the Seller/Server Training Evaluation form. The following steps should be completed to submit a training program for approval:

1. Complete the Alcohol Seller/Server Training Data Sheet and review the Seller/Server Training Evaluation form to make sure the program will meet the listed criteria; and

2. Submit the Alcohol Seller/Server Training Data Sheet and a copy of the proposed training program materials for review. Materials submitted should include copies of any

lesson plans and instructional materials used in the training program.

Requests for certification of training courses should be sent to:

Virginia ~~Department of~~ Alcoholic Beverage Control Authority

Education Section

P.O. Box 27491

Richmond, VA 23261

Email ~~correspondences~~: education@abc.virginia.gov

Persons in charge of any certified alcohol server training course shall maintain complete records of all training classes conducted, including the date and location of each class~~,~~ and the identity of all those successfully completing the course.

C. For a licensee that operates more than one retail establishment, each such establishment shall be considered a separate licensee for the purpose of this section.

VA.R. Doc. No. R18-5365; Filed February 8, 2019, 7:47 a.m.

TITLE 12. HEALTH

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Proposed Regulation

Titles of Regulations: **12VAC30-10. State Plan under Title XIX of the Social Security Act Medical Assistance Program; General Provisions (amending 12VAC30-10-540).**

12VAC30-50. Amount, Duration, and Scope of Medical and Remedial Care Services (amending 12VAC30-50-20, 12VAC30-50-30, 12VAC30-50-60, 12VAC30-50-70, 12VAC30-50-130, 12VAC30-50-226).

12VAC30-60. Standards Established and Methods Used to Assure High Quality Care (amending 12VAC30-60-5, 12VAC30-60-50, 12VAC30-60-61).

12VAC30-130. Amount, Duration and Scope of Selected Services (repealing 12VAC30-130-850, 12VAC30-130-860, 12VAC30-130-870, 12VAC30-130-880, 12VAC30-130-890).

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: May 3, 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 and promulgate regulations. 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 and promulgate regulations. The Medicaid authority as established by § 1902(a) of the Social Security Act (42 USC § 1396a) provides governing authority for payments for services.

The agency is proposing this regulatory action to comply with Item 301 OO and Item 301 PP of Chapter 665 of the 2015 Acts of Assembly. Items 301 PP states: "The Department of Medical Assistance Services shall make programmatic changes in the provision of Residential Treatment Facility (Level C) and Levels A and B residential services (group homes) for children with serious emotional disturbances in order to ensure appropriate utilization and cost efficiency. The department shall consider all available options including, but not limited to, prior authorization, utilization review and provider qualifications. The department shall have authority to promulgate regulations to implement these changes within 280 days or less from the enactment date of this act."

Purpose: This regulatory action is essential to protect the health, safety, or welfare of Medicaid-covered individuals who require behavioral health services and their families to ensure that families are well informed about their family member's behavioral health condition about service options prior to receiving these services, that the services are medically necessary, and that the services are rendered by providers who use evidence-based treatment approaches.

When residential treatment services were initially implemented by DMAS, individuals did not have access to standardized methods of effective care coordination upon entry into residential treatment due to placement processes at the time and DMAS reimbursement limitations. This resulted in a fragmented coordination approach for these individuals who were at risk for high levels of care and remained at risk of repeated placements at this level of care. Also, at the time of the appropriations act mandate, the process in place for Medicaid enrolled children placed in residential settings yielded an average stay of 260 days and had high readmission rates.

While residential treatment is not a service that should be approved with great frequency for a large number of individuals, it is a service that should be accessible to the families and individuals who require that level of care. The

service model had significant operational layers to be navigated to access residential services. The processes involved coordination of care by local family access and planning teams (FAPTs) who have, over time, demonstrated some influence on determining an individual's eligibility for FAPT funded services. The local influence on the programs administration caused limitations on individualized freedom of provider choice and inconsistent authorization of funding for persons deemed to need psychiatric care out of the home setting. This local administration of the primary referral source for residential treatment was outside the purview of DMAS, and this situation produced outcomes that are inadequate to meet Centers for Medicare and Medicaid Services (CMS) requirements on ensuring the individual freedom of choice of providers.

Also, the state rules on FAPT composition were not consistent with the federal Medicaid requirement for certifying a child for Medicaid-funded residential treatment placement. Changes to the program were necessary to address concerns that arose from the reliance upon the FAPT to fulfill the role as the federally mandated independent team to certify residential treatment.

The residential treatment model requires an enhanced care coordination model to support the individuals who receive this level of service to ensure an effective return to the family or caregiver home environment with follow up services to facilitate ongoing treatment progress in the least restrictive environment. The added coordination is required to navigate a very complex service environment for the individual as the individual returns to a community setting to establish an effective aftercare environment that involves service providers who may be contracted with a variety of entities such as DMAS contracted managed care organizations (MCOs), enrolled providers, the local FAPT team, local school divisions, and the local community services board (CSB). The proposed amendments allow DMAS to implement a contracted care coordination team to focus on attaining specific clinical outcomes for all residential care episodes and to provide a single liaison who will ensure coordination of care in a complex service environment for individuals upon discharge from residential treatment and prior to the time when they will enroll in an MCO. During this transition period, the individual is very vulnerable to repeated admissions to residential or inpatient care and must be supported in the fee-for-service (FFS) environment with resources from the local CSB and enrolled service providers and requires ongoing support and coordination to receive post-discharge follow up and transition services.

DMAS has the goal that individuals receive the correct level of service at the correct time for the treatment (service) needs related to the individual's medical or psychiatric condition. Residential treatment services consist of behavioral health interventions and are intended to provide high intensity clinical treatment that should be provided for a short duration. Stakeholder feedback supported observations by DMAS of lengthy durations of stay for many individuals. Residential treatment services will benefit from clarification of the service definition and eligibility requirements to ensure that residential treatment does not evolve into a long-term level of support instead of the high intensity psychiatric treatment modality that defines this level of care.

Substance: The sections of the State Plan for Medical Assistance that are affected by this action are: Inspection of Care in Intermediate Care Facilities (12VAC30-10-540), Mandatory Coverage: Categorically Needy and other required special groups (12VAC30-30-10), the Amount, Duration, and Scope of Medical and Remedial Services Provided to Categorically/Medically Needy Individuals-EPSDT Services (12VAC30-50-130); Applicability of utilization review requirements (12VAC30-60-5), Utilization control: Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and Institutions for Mental Disease (IMD) (12VAC30-60-50) and Services related to the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT); community mental health services for children (12VAC30-60-61). The state-only regulations that are affected by this action are Residential Psychiatric Treatment for Children and Adolescents (plans of care; review of plans of care (12VAC30-130-850 through 130-890).

The proposed regulatory action will serve to better clarify policy interpretations that revise program standards to allow for more evidence based service delivery, allow DMAS to implement more effective utilization management in collaboration with the BHSA, enhance individualized coordination of care, implement standardized coordination of individualized aftercare resources by ensuring access to medical and behavioral health service providers in the individual's home community, and support DMAS audit practices. The proposed regulatory changes move toward a service model that will reduce lengths of stay and facilitate an evidence based treatment approach to better support the individual's discharge into their home environment. These changes also align DMAS in meeting the requirements set forth by the Centers for Medicare and Medicaid Services (CMS) in 42 CFR 441 Subpart D and 42 CFR 441.453.

The proposed regulatory action incorporates changes made in the emergency regulation, including changes to the following areas: (i) provider qualifications including acceptable licensing standards; (ii) preadmission assessment requirements, (iii) program requirements; (iv) new discharge planning and care coordination requirements; and (iv) language enhancements for utilization review requirements to clarify program requirements, to ensure adequate documentation of service delivery, and to help providers avoid payment retractions. These changes are part of a review of the services to ensure that services are effectively delivered and utilized for individuals who meet the medical necessity criteria. For each individual seeking residential treatment

treatment needs are assessed with enhanced requirements by the current independent certification teams who coordinate clinical assessment information and assess local resources for each individual requesting residential care to determine an appropriate level of care. The certification teams are also better able to coordinate referrals for care to determine, in accordance with DOJ requirements, whether or not the individual seeking services can be safely served using community based services in the least restrictive setting. Independent team certifications are conducted prior to the onset of specified services, as required by CMS guidelines, by the DMAS behavioral health services administrator.

The proposed regulatory action includes changes to program requirements that ensure that effective levels of care coordination and discharge planning occurs for each individual during the individual's residential stay by enhancing program rules and utilization management principles that facilitate effective discharge planning, family engagement and establish community-based services prior to the individual's discharge from residential care. The proposed regulatory action requires enhanced care coordination to provide the necessary objective evaluations of treatment progress and to facilitate evidence based practices during the treatment to reduce the length of stay by ensuring that medical necessity indicates the correct level of care and that appropriate and effective care is delivered in a person centered manner. The proposed regulatory action requires that service providers and local systems use standardized preadmission and discharge processes to ensure effective services are delivered.

Issues: The primary advantages of the proposed regulatory action to the Commonwealth and to Medicaid members are that the proposed amendments (i) better clarify policy interpretations that revise program standards to allow for more evidence based service delivery, (ii) allow DMAS to implement more effective utilization management in collaboration with the behavioral health services administrator, (iii) enhance individualized coordination of care and implement standardized coordination of individualized aftercare resources by ensuring access to medical and behavioral health service providers in the individual's home community, (iv) support DMAS audit practices, and (v) move toward a service model that will reduce lengths of stay and facilitate an evidence based treatment approach to better support the individual's discharge into their home environment. There are no disadvantages to the Commonwealth or the public as a result of the proposed regulatory action.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. Pursuant to legislative mandates, the Board of Medical Assistance Services (Board) proposes numerous changes to the provision of psychiatric residential treatment services. These changes were already implemented under an emergency regulation on July 1, 2017.[1] The proposed regulation is a permanent replacement for the emergency regulation.

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

Estimated Economic Impact. Pursuant to Item 301 OO paragraphs 7 through 18 and Item 301 PP of Chapter 665 of the 2015 Acts of Assembly, the Board proposes to eliminate Level A group homes as they did not meet the federal Centers for Medicare and Medicaid Services requirements and to change the definition of "Level B" group homes to "Therapeutic Group Homes." In response to the legislative mandates, the Board also proposes changes to plan of care requirements, medical necessity requirements, discharge planning, required clinical activities and documentation for Therapeutic Group Homes (TGH); changes to Early and Periodic Screening, Diagnostic and Treatment criteria, Independent Assessment, Certification and Coordination Team (IACCT) provider requirements and required activities, admission practices, and plan of care requirements for Psychiatric Residential Treatment Facilities (PRTF); and changes to service authorization and continued stay requirements both for PRTF and TGH.

According to DMAS, since 2001, when residential treatment services were first implemented, individuals have not had access to standardized methods of effective care coordination upon entry into residential treatment due to locality influence and DMAS reimbursement limitations. This has resulted in a fragmented coordination approach for these individuals who are at risk for high level care and remain at risk of repeated placements at this level of care. The residential treatment prior authorization and utilization management structures require an enhanced care coordination model to support the individuals who receive this level of service to ensure an effective return to the family or caregiver home environment with follow up services to facilitate ongoing treatment progress in the least restrictive environment. The added coordination is required to navigate a very complex service environment for the individual as they return to a community setting to establish an effective aftercare environment that involves service providers who may be contracted with a variety of entities such as managed care organizations, enrolled providers, the local Family Assessment and Planning Team (FAPT), local school divisions and the local Community Service Boards.

DMAS states that FAPT composition prior to the emergency regulation was not consistent with the federal Medicaid requirement for certifying a child for a Medicaid-funded residential treatment placement. Changes to the program were necessary to address the concerns that arose from the reliance upon the FAPT to fulfill the role as the federally mandated

independent team to certify residential treatment. The emergency regulation implemented the IACCT approach to attain specific clinical outcomes for all residential care episodes prior to managed care enrollment thorough discharge from residential treatment. IACCT ensures meaningful communication across all parts of the Children's Services Act providers, Department of Behavioral Health and Developmental Services, Managed Care Organizations, and fee-for-servicer systems to maximize efficiency of activities, eliminate duplicative and/or conflicting efforts, and ensure established timelines are met. In addition, the Virginia Independent Clinical Assessment Program (VICAP) process was originally used to streamline high quality comprehensive assessments for services; however, VICAP was sunset in order to use funds to pay for the IACCT.

These proposed changes are intended to ensure appropriate utilization and cost efficiencies. Prior to the emergency regulation, the total expenditures relating to the affected services were approximately $113 million. In fiscal year 2018, the total expenditures decreased to $89.2 million. While the precise total financial impact of these changes have not been quantified, available data show that members utilizing PRTF have decreased from 1,104 in the first quarter of 2016 to 887 in the third quarter of 2018 (a 20% reduction); that members utilizing TGH have decreased from 349 in the first quarter of 2016 to 311 in the third quarter of 2018 (an 11% reduction); that members utilizing Level A group homes have decreased from 349 in the first quarter of 2016 to 0 in the third quarter of 2018 (because it was completely eliminated); that average length of stay in PRTF decreased from 215.2 days to 209 days (a 6.2-day reduction); and that average length of stay in TGH decreased from 142.8 days to 120.9 days (a 21.9-day reduction).

Moreover, between September 2017 and August 2018, 3,231 IACCT inquiries were received; 2,353 of these inquiries were referred for assessment. Primary reasons for inquiries not leading to assessment included families not returning calls, families deciding to continue with community services instead, members being placed in juvenile detention, and families declining residential services; 2,009 of the assessments recommended a residential placement (1,421 PRTF and 588 in a TGH). The remaining 344 individuals who received an assessment but were not recommended for a residential placement, were recommended for community services.

According to DMAS, the proposed changes are essential for compliance with 42 CFR 441.153, which is prerequisite for federal match and for members to receive services as appropriate.

Finally, this regulation has not been updated since 2001 when psychiatric residential treatment services were first provided. Since then major changes have occurred such as provision of behavioral health services through Magellan, the Behavioral Health Service Administrator, implementation of more evidence based service delivery systems, enhanced individualized coordination of care, audit practices, etc. As a result, the proposed changes also clarify provider qualifications including licensing standards; preadmission assessment requirements, program requirements, discharge planning and care coordination requirements in greater detail. Changes such as those are not expected to create any significant economic impact upon promulgation of this regulation. Added clarity of the regulatory requirements however would improve compliance and produce a net benefit.

Businesses and Entities Affected. This regulation applies to 90 therapeutic group homes, 18 residential treatment facilities, 23 organizations (including Community Service Boards, Comprehensive Services Act providers, and private entities) providing Independent Assessment Certification and Coordination services, and 128 Family Assessment and Planning Teams.

Localities Particularly Affected. No locality should be affected any more than others.

Projected Impact on Employment. The proposed amendments were implemented in July 2017. No impact on employment is expected upon promulgation of the proposed amendments. However, the implementation of the emergency regulations may have had a negative impact on group homes' and residential treatment facilities' demand for labor to the extent it improved efficiencies and eliminated duplicative and/or conflicting efforts. The establishment of the IACCT approach should have added to demand for labor for them to perform their functions.

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

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. The proposed amendments do not impose costs on small businesses; however, to the extent they improve efficiencies and eliminate duplicative and/or conflicting efforts, they may reduce group homes and residential treatment facility revenues.

Alternative Method that Minimizes Adverse Impact. There is no known alternative method that would minimize the adverse impact while accomplishing the same goals.

Adverse Impacts:

Businesses. The proposed amendments should not adversely affect businesses upon promulgation.

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]http://townhall.virginia.gov/L/viewstage.cfm?stageid=7424

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 proposed regulatory action implements Items 301 OO and 301 PP of Chapter 665 of the 2015 Acts of Assembly, which required the department to develop and implement a care coordination model and make programmatic changes in the provision of residential treatment for children. The proposed action replaces emergency regulations published in 33:13 VA.R. 1436-1469 February 20, 2017, and extended in 35:9 VA.R. 1130 December 24, 2018.

The proposed amendments clarify policy interpretations and revise program standards to allow for more evidence-based service delivery, allow the department to implement more effective utilization management in collaboration with the behavioral health service administrator, enhance individualized coordination of care, implement standardized coordination of individualized aftercare resources by ensuring access to medical and behavioral health service providers in the individual's home community, and support department audit practices. The proposed action meets the requirements set forth by the Centers for Medicare and Medicaid Services (CMS) in 42 CFR 441 Subpart D and 42 CFR 441.453.

The proposed amendments include changes to the following areas: (i) provider qualifications, including acceptable licensing standards; (ii) preadmission assessment requirements; (iii) program requirements; (iv) new discharge planning and care coordination requirements; and (v) language enhancements for utilization review requirements to clarify program requirements, ensure adequate documentation of service delivery, and help providers avoid payment retractions.

The proposed action requires enhanced care coordination to provide the necessary objective evaluations of treatment progress and to facilitate evidence-based practices during the treatment to reduce the length of stay by ensuring that medical necessity indicates the correct level of care, that appropriate and effective care is delivered in a person centered manner, and that service providers and local systems use standardized preadmission and discharge processes to ensure effective services are delivered.

12VAC30-10-540. Inspection of care in intermediate care facilities for ~~the mentally retarded~~ persons with intellectual and developmental disabilities, facilities providing inpatient psychiatric services for individuals ~~under~~ younger than 21 years of age, and mental hospitals.

All applicable requirements of 42 CFR 456, Subpart I~~,~~ are met with respect to periodic inspections of care and services.~~*~~

~~Inpatient psychiatric services for individuals under age 21 are not provided under this plan.~~

~~*Inspection of Care (IOC) in Intermediate Care Facilities for the Mentally Retarded and Institutions for Mental Diseases are~~ Inspection of care in intermediate care facilities for persons with intellectual and developmental disabilities is completed through contractual arrangements with the Virginia Department of Health.

12VAC30-50-20. Services provided to the categorically needy without limitation.

The following services as described in Part III (12VAC30-50-100 et seq.) of this chapter are provided to the categorically needy without limitation:

1. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

2. Services for individuals ~~age~~ 65 years of age or ~~over~~ older in institutions for mental diseases: inpatient hospital services; skilled nursing facility services; and services in an intermediate care facility.

3. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with § 1902(a)(31)(A) of the Social Security Act (the Act), to be in need of such care, including such services in a public institution (or distinct part thereof) for ~~the mentally retarded or~~ persons with intellectual or developmental disability or related conditions.

4. Hospice care (in accordance with § 1905(o) of the Act).

5. Any other medical care and any type of remedial care recognized under state law, specified by the U.S. Secretary of Health and Human Services: care and services provided in religious nonmedical health care institutions~~;~~, nursing facility services for patients ~~under~~ younger than 21 years of age~~;~~, or emergency hospital services.

6. Private health insurance premiums, coinsurance, and deductibles when cost effective (pursuant to ~~Pub. L.~~ P.L. No. 101-508 § 4402).

7. Program of All-Inclusive Care for the Elderly (PACE) services are provided for eligible individuals as an optional State Plan service for categorically needy individuals without limitation.

8. Pursuant to ~~Pub. L.~~ P.L. No. 111-148 § 4107, counseling and pharmacotherapy for cessation of tobacco use by pregnant women shall be covered.

a. Counseling and pharmacotherapy for cessation of tobacco use by pregnant women means diagnostic, therapy, and counseling services and pharmacotherapy (including the coverage of prescription and nonprescription tobacco cessation agents approved by the U.S. Food and Drug Administration) for cessation of tobacco use by pregnant women who use tobacco products or who are being treated for tobacco use that is furnished (i) by or under the supervision of a physician, (ii) by any other health care professional who is legally authorized to provide tobacco cessation services under state law and is authorized to provide Medicaid coverable services other than tobacco cessation services, or (iii) by any other health care professional who is legally authorized to provide tobacco cessation services under state law and who is specifically designated by the U.S. Secretary of Health and Human Services in federal regulations for this purpose.

b. No cost sharing shall be applied to these services. In addition to other services that are covered for pregnant women, 12VAC30-50-510 also provides for other smoking cessation services that are covered for pregnant women.

9. Inpatient psychiatric facility services and residential psychiatric treatment services (including therapeutic group homes and psychiatric residential treatment facilities) for individuals younger than 21 years of age.

12VAC30-50-30. Services not provided to the categorically needy.

The following services and devices are not provided to the categorically needy:

1. ~~Chiropractors'~~ Chiropractor services.

2. Private duty nursing services.

3. Dentures.

4. Other diagnostic and preventive services other than those provided elsewhere in this plan: diagnostic services (~~see~~ 12VAC30-50-95 ~~et seq.~~).

5. ~~Inpatient psychiatric facility services for individuals under 21 years of age, other than those covered under early and periodic screening, diagnosis, and treatment (at 12VAC30-50-130).~~ (Reserved.)

6. Special tuberculosis ~~(TB)~~ related services under § 1902(z)(2)(F) of the Social Security Act (the Act).

7. Respiratory care services (in accordance with § 1920(e)(9)(A) through (C) of the Act).

8. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a qualified provider (in accordance with § 1920 of the Act).

9. Any other medical care and any type of remedial care recognized under state law specified by the U.S. Secretary of Health and Human Services: personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

12VAC30-50-60. Services provided to all medically needy groups without limitations.

Services as described in Part III (12VAC30-50-100 et seq.) of this chapter are provided to all medically needy groups without limitations.

1. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

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

3. Pursuant to ~~Pub. L.~~ P.L. No. 111-148 § 4107, counseling and pharmacotherapy for cessation of tobacco use by pregnant women shall be covered.

a. Counseling and pharmacotherapy for cessation of tobacco use by pregnant women means diagnostic, therapy, and counseling services and pharmacotherapy (including the coverage of prescription and nonprescription tobacco cessation agents approved by the U.S. Food and Drug Administration) for cessation of tobacco use by pregnant women who use tobacco products or who are being treated for tobacco use that is furnished (i) by or under the supervision of a physician, (ii) by any other health care professional who is legally authorized to provide tobacco cessation services under state law and is authorized to provide Medicaid coverable services other than tobacco cessation services, or (iii) by any other health care professional who is legally authorized to provide tobacco cessation services under state law and who is specifically designated by the U.S. Secretary of Health and Human Services in federal regulations for this purpose.

b. No cost sharing shall be applied to these services. In addition to other services that are covered for pregnant women, 12VAC30-50-510 also provides for other smoking cessation services that are covered for pregnant women.

4. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with § 1905(a)(4)(A) of the Social Security Act (the Act) to be in need of such care.

5. Hospice care (in accordance with § 1905(o) of the Act).

6. Any other medical care or any other type of remedial care recognized under state law, specified by the ~~secretary~~ U.S. Secretary of Health and Human Services, including: care and services provided in religious nonmedical health care institutions~~;~~, skilled nursing facility services for patients ~~under~~ younger than 21 years of age~~;~~, and emergency hospital services.

7. Private health insurance premiums, coinsurance and deductibles when cost effective (pursuant to ~~Pub. L.~~ P.L. No. 101-508 § 4402).

8. Program of All-Inclusive Care for the Elderly (PACE) services are provided for eligible individuals as an optional State Plan service for medically needy individuals without limitation.

9. Inpatient psychiatric facility services and residential psychiatric treatment services (including therapeutic group homes and psychiatric residential treatment facilities) for individuals younger than 21 years of age.

12VAC30-50-70. Services or devices not provided to the medically needy.

1. ~~Chiropractors'~~ Chiropractor services.

2. Private duty nursing services.

3. Dentures.

4. Diagnostic or preventive services other than those provided elsewhere in the State Plan.

5. Inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals ~~age~~ 65 years of age or older in institutions for mental ~~disease(s)~~ diseases.

6. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with § 1905(a)(4)(A) of the Social Security Act (the Act), to be in need of such care in a public institution, or a distinct part thereof, for ~~the mentally retarded or~~ persons with intellectual or developmental disability or related conditions.

7. ~~Inpatient psychiatric facility services for individuals under 21 years of age, other than those covered under early and periodic screening, diagnosis, and treatment (at 12VAC30-50-130).~~ (Reserved.)

8. Special tuberculosis ~~(TB)~~ services under § 1902(z)(2)(F) of the Act.

9. Respiratory care services (in accordance with § 1920(e)(9)(A) through (C) of the Act).

10. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a qualified provider (in accordance with § 1920 of the Act).

11. Personal care services in a recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

12. Home and community care for functionally disabled elderly individuals, as defined, described and limited in ~~12VAC30-50-460 and~~ 12VAC30-50-470.

13. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for ~~the mentally retarded~~ intellectually or developmentally disabled persons, or institution for mental disease that are (i) authorized for the individual by a physician in accordance with a plan of treatment, (ii) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (iii) furnished in a home.

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~~ General provisions for early and periodic screening ~~and~~, diagnosis, and treatment (EPSDT) 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 departments of 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~~

DMAS shall place appropriate utilization controls upon this service.

4. Consistent with § 6403 of 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 ~~age~~s 21 years of age and older, provided for by § 1905(a) of the Social Security Act.

~~5.~~ C. Community mental health services provided through early and periodic screening diagnosis and treatment (EPSDT) for individuals younger than 21 years of age. 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~~ shall be reflected in provider records and on ~~providers'~~ provider claims for services by recognized diagnosis codes that support and are consistent with the requested professional services.

~~a.~~ 1. 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~~ this term, 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 the 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.~~

"Child" means an individual ages birth through 11 years.

"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~~ the Department of Health Professions in the document entitled ~~Human Services and Related~~

~~Fields Approved Degrees/Experience, issued March 12, 2013, revised May 3, 2013~~ Approved Degrees in Human Services and Related Fields for QMHP Registration, adopted November 3, 2017, revised February 9, 2018.

"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 including a "QMHP-trainee" as defined by the Department of Health Professions.

"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~~ issue or 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~~ educational or 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.~~ 2. 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~~,~~ and 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 of psychoeducation 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~~ the individual's 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)~~ a. 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)~~ b. Service-specific provider intakes shall be required prior to the start of services 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)~~ c. These services ~~may~~ shall only be rendered by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, or a QMHP-E.

~~c.~~ 3. Therapeutic day treatment (TDT) shall be provided two or more hours per day in order to provide therapeutic interventions (a unit is defined in 12VAC30-60-61 D 11). 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)~~ a. Service authorization shall be required for Medicaid reimbursement.

~~(2)~~ b. Service-specific provider intakes shall be required ~~at~~ prior to the ~~onset~~ start 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)~~ c. These services ~~may~~ shall 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.~~

D. Therapeutic group home services and psychiatric residential treatment facility (PRTF) services for early and periodic screening diagnosis and treatment (EPSDT) of individuals younger than 21 years of age.

1. Definitions. The following words and terms when used in this subsection shall have the following meanings:

"Active treatment" means implementation of an initial plan of care (IPOC) and comprehensive individual plan of care (CIPOC).

"Assessment" means the face-to-face interaction by an LMHP, LMHP-R, LMHP-RP, or LMHP-S to obtain information from the child or adolescent and parent, guardian, or other family member, as appropriate, utilizing a tool or series of tools to provide a comprehensive evaluation and review of the child's or adolescent's mental health status. The assessment shall include a documented history of the severity, intensity, and duration of mental health problems and behavioral and emotional issues.

"Certificate of need" or "CON" means a written statement by an independent certification team that services in a therapeutic group home or PRTF are or were needed.

"Combined treatment services" means a structured, therapeutic milieu and planned interventions that promote (i) the development or restoration of adaptive functioning, self-care, and social skills; (ii) community integrated activities and community living skills that each individual requires to live in less restrictive environments; (iii) behavioral consultation; (iv) individual and group therapy; (v) skills restoration, the restoration of coping skills, family living and health awareness, interpersonal skills, communication skills, and stress management skills; (vi) family education and family therapy; and (vii) individualized treatment planning.

"Comprehensive individual plan of care" or "CIPOC" means a person centered plan of care that meets all of the requirements of this subsection and is specific to the individual's unique treatment needs and acuity levels as identified in the clinical assessment and information gathered during the referral process.

"Crisis" means a deteriorating or unstable situation that produces an acute, heightened emotional, mental, physical, medical, or behavioral event.

"Crisis management" means immediately provided activities and interventions designed to rapidly manage a

crisis. The activities and interventions include behavioral health care to provide immediate assistance to individuals experiencing acute behavioral health problems that require immediate intervention to stabilize and prevent harm and higher level of acuity. Activities shall include assessment and short-term counseling designed to stabilize the individual. Individuals are referred to long-term services once the crisis has been stabilized.

"Daily supervision" means the supervision provided in a PRTF through a resident-to-staff ratio approved by the Office of Licensure at the Department of Behavioral Health and Developmental Services with documented supervision checks every 15 minutes throughout a 24-hour period.

"Discharge planning" means family and locality-based care coordination that begins upon admission to a PRTF or therapeutic group home with the goal of transitioning the individual out of the PRTF or therapeutic group home to a less restrictive care setting with continued, clinically-appropriate, and possibly intensive, services as soon as possible upon discharge. Discharge plans shall be recommended by the treating physician, psychiatrist, or treating LMHP responsible for the overall supervision of the plan of care and shall be approved by the DMAS contractor.

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

"Emergency admissions" means those admissions that are made when, pending a review for the certificate of need, it appears that the individual is in need of an immediate admission to a therapeutic group home or PRTF and likely does not meet the medical necessity criteria to receive crisis intervention, crisis stabilization, or acute psychiatric inpatient services.

"Emergency services" means unscheduled and sometimes scheduled crisis intervention, stabilization, acute psychiatric inpatient services, and referral assistance provided over the telephone or face-to-face if indicated, and available 24 hours a day, seven days per week.

"Family engagement" means a family-centered and strengths-based approach to partnering with families in making decisions, setting goals, achieving desired outcomes, and promoting safety, permanency, and well-being for children, adolescents, and families. Family engagement requires ongoing opportunities for an individual to build and maintain meaningful relationships with family members, for example, frequent, unscheduled, and noncontingent telephone calls and visits between an individual and family members. Family engagement may also include enhancing or facilitating the development of the individual's relationship with other family members and supportive adults responsible for the individual's care and well-being upon discharge.

"Family engagement activity" means an intervention consisting of family psychoeducational training or coaching, transition planning with the family, family and independent living skills, and training on accessing community supports as identified in the plan of care. Family engagement activity does not include and is not the same as family therapy.

"Family therapy" means counseling services involving the individual's family and significant others to advance the treatment goals when (i) the counseling with the family member and significant others is for the direct benefit of the individual, (ii) the counseling is not aimed at addressing treatment needs of the individual's family or significant others, and (iii) the individual is present except when it is clinically appropriate for the individual to be absent in order to advance the individual's treatment goals. Family therapy shall be aligned with the goals of the individual's plan of care. All family therapy services furnished are for the direct benefit of the individual, in accordance with the individual's needs and treatment goals identified in the individual's plan of care, and for the purpose of assisting in the individual's recovery.

"FAPT" means the family assessment and planning team.

"ICD-10" means International Statistical Classification of Diseases and Related Health Problems, 10th Revision, published by the World Health Organization.

"Independent certification team" means a team that has competence in diagnosis and treatment of mental illness, preferably in child psychiatry; has knowledge of the individual's situation; and is composed of at least one physician and one LMHP. The independent certification team shall be a DMAS-authorized contractor with contractual or employment relationships with the required team members.

"Individual" means the child or adolescent younger than 21 years of age who is receiving therapeutic group home or PRTF services.

"Individual and group therapy" means the application of principles, standards, and methods of the counseling profession in (i) conducting assessments and diagnosis for the purpose of establishing treatment goals and objectives and (ii) planning, implementing, and evaluating plans of care using treatment interventions to facilitate human development and to identify and remediate mental, emotional, or behavioral disorders and associated distresses that interfere with mental health.

"Initial plan of care" or "IPOC" means a person centered plan of care established at admission that meets all of the requirements of this subsection and is specific to the

individual's unique treatment needs and acuity levels as identified in the clinical assessment and information gathered during the referral process.

"Intervention" means scheduled therapeutic treatment such as individual or group psychoeducation; skills restoration; structured behavior support and training activities; recreation, art, and music therapies; community integration activities that promote or assist in the child's or adolescent's ability to acquire coping and functional or self-regulating behavior skills; day and overnight passes; and family engagement activities. Interventions shall not include individual, group, and family therapy; medical or dental appointments; or physician services, medication evaluation, or management provided by a licensed clinician or physician and shall not include school attendance. Interventions shall be provided in the therapeutic group home or PRTF and, when clinically necessary, in a community setting or as part of a therapeutic pass. All interventions and settings of the intervention shall be established in the plan of care.

"Plan of care" means the initial plan of care (IPOC) and the comprehensive individual plan of care (CIPOC).

"Physician" means an individual licensed to practice medicine or osteopathic medicine in Virginia, as defined in § 54.1-2900 of the Code of Virginia.

"Psychiatric residential treatment facility" or "PRTF" means the same as defined in 42 CFR 483.352 and is a 24-hour, supervised, clinically and medically necessary, out-of-home active treatment program designed to provide necessary support and address mental health, behavioral, substance abuse, cognitive, and training needs of an individual younger than 21 years of age in order to prevent or minimize the need for more intensive treatment.

"Recertification" means a certification for each applicant or recipient for whom therapeutic group home or PRTF services are needed.

"Room and board" means a component of the total daily cost for placement in a licensed PRTF. Residential room and board costs are maintenance costs associated with placement in a licensed PRTF and include a semi-private room, three meals and two snacks per day, and personal care items. Room and board costs are reimbursed only for PRTF settings.

"Services provided under arrangement" means services including physician and other health care services that are furnished to children while they are in a freestanding psychiatric hospital or PRTF that are billed by the arranged practitioners separately from the freestanding psychiatric hospital's or PRTF's per diem.

"Skills restoration" means a face-to-face service to assist individuals in the restoration of lost skills that are necessary to achieve the goals established in the beneficiary's plan of care. Services include assisting the individual in restoring self-management, interpersonal, communication, and problem solving skills through modeling, coaching, and cueing.

"Therapeutic group home" means a congregate residential service providing 24-hour supervision in a community-based home having eight or fewer residents.

"Therapeutic pass" means time at home or time with family consisting of partial or entire days of time away from the therapeutic group home or psychiatric residential treatment facility as clinically indicated in the plan of care and as paired with facility-based and community-based interventions to promote discharge planning, community integration, and family engagement activities. Therapeutic passes are not recreational but are a therapeutic component of the plan of care and are designed for the direct benefit of the individual.

"Treatment planning" means development of a person centered plan of care that is specific to the individual's unique treatment needs and acuity levels.

~~e.~~ 2. Therapeutic ~~behavioral~~ group home 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)~~ a. Therapeutic group home services for children and adolescents younger than 21 years of age shall provide therapeutic services to restore or maintain appropriate skills necessary to promote prosocial behavior and healthy living, including skills restoration, family living and health awareness, interpersonal skills, communication skills, and stress management skills.

Therapeutic services shall also engage families and reflect family-driven practices that correlate to sustained positive outcomes post-discharge for youth and their family members. Each component of therapeutic group home services is provided for the direct benefit of the individual, in accordance with the individual's needs and treatment goals identified in the individual's plan of care, and for the purpose of assisting in the individual's recovery. These services are provided under 42 CFR 440.130(d) in accordance with the rehabilitative services benefit.

b. The plan of care shall include individualized activities, including a minimum of one intervention per 24-hour period in addition to individual, group, and family therapies. Daily interventions are not required when there is documentation to justify clinical or medical reasons for the individual's deviations from the plan of care. Interventions shall be documented on a progress note and shall be outlined in and aligned with the treatment goals and objectives in the IPOC and CIPOC. Any deviation from the plan of care shall be documented along with a clinical or medical justification for the deviation.

c. Medical necessity criteria for admission to a therapeutic group home. The following requirements for severity of need and intensity and quality of service shall be met to satisfy the medical necessity criteria for admission.

(1) Severity of need required for admission. All of the following criteria shall be met to satisfy the criteria for severity of need:

(a) The individual's behavioral health condition can only be safely and effectively treated in a 24-hour therapeutic milieu with onsite behavioral health therapy due to significant impairments in home, school, and community functioning caused by current mental health symptoms consistent with a DSM-5 diagnosis.

(b) The certificate of need must demonstrate all of the following: (i) ambulatory care resources (all available modalities of treatment less restrictive than inpatient treatment) available in the community do not meet the treatment needs of the individual; (ii) proper treatment of the individual's psychiatric condition requires services on an inpatient basis under the direction of a physician; and (iii) the services can reasonably be expected to improve the individual's condition or prevent further regression so that the services will no longer be needed.

(c) The state uniform assessment tool shall be completed. The assessment shall demonstrate at least two areas of moderate impairment in major life activities. A moderate impairment is defined as a major or persistent disruption in major life activities. A moderate impairment is evidenced by, but not limited to (i) frequent conflict in the family setting such as credible threats of physical harm, where "frequent" means more than expected for the individual's age and developmental level; (ii) frequent inability to accept age-appropriate direction and supervision from caretakers, from family members, at school, or in the home or community; (iii) severely limited involvement in social support, which means significant avoidance of appropriate social interaction, deterioration of existing relationships, or refusal to participate in therapeutic interventions; (iv) impaired ability to form a trusting relationship with at least one caretaker in the home, school, or community; (v) limited ability to consider the effect of one's inappropriate conduct on others; and (vi) interactions consistently involving conflict, which may include impulsive or abusive behaviors.

(d) Less restrictive community-based services have been given a fully adequate trial and were unsuccessful or, if not attempted, have been considered, but in either situation were determined to be unable to meet the individual's treatment needs and the reasons for that are discussed in the certificate of need.

(e) The individual's symptoms, or the need for treatment in a 24 hours a day, seven days a week level of care (LOC), are not primarily due to any of the following: (i) intellectual disability, developmental disability, or autistic spectrum disorder; (ii) organic mental disorders, traumatic brain injury, or other medical condition; or (iii) the individual does not require a more intensive level of care.

(f) The individual does not require primary medical or surgical treatment.

(2) Intensity and quality of service necessary for admission. All of the following criteria shall be met to satisfy the criteria for intensity and quality of service:

(a) The therapeutic group home service has been prescribed by a psychiatrist, psychologist, or other LMHP who has documented that a residential setting is the least restrictive clinically appropriate service that can meet the specifically identified treatment needs of the individual.

(b) The therapeutic group home is not being used for clinically inappropriate reasons, including (i) an alternative to incarceration or preventative detention; (ii) an alternative to a parent's, guardian's, or agency's capacity to provide a place of residence for the individual; or (iii) a treatment intervention when other less restrictive alternatives are available.

(c) The individual's treatment goals are included in the service specific provider intake and include behaviorally defined objectives that require and can reasonably be achieved within a therapeutic group home setting.

(d) The therapeutic group home is required to coordinate with the individual's community resources, including schools and FAPT as appropriate, with the goal of transitioning the individual out of the program to a less restrictive care setting for continued, sometimes intensive, services as soon as possible and appropriate.

(e) The therapeutic group home program must incorporate nationally established, evidence-based, trauma-informed services and supports that promote recovery and resiliency.

(f) Discharge planning begins upon admission, with concrete plans for the individual to transition back into the community beginning within the first week of admission, with clear action steps and target dates outlined in the plan of care.

(3) Continued stay criteria. The following criteria shall be met in order to satisfy the criteria for continued stay:

(a) All of the admission guidelines continue to be met and continue to be supported by the written clinical documentation.

(b) The individual shall meet one of the following criteria: (i) the desired outcome or level of functioning has not been restored or improved in the timeframe outlined in the individual's plan of care or the individual continues to be at risk for relapse based on history or (ii) the nature of the functional gains is tenuous and use of less intensive services will not achieve stabilization.

(c) The individual shall meet one of the following criteria: (i) the individual has achieved initial CIPOC goals, but additional goals are indicated that cannot be met at a lower level of care; (ii) the individual is making satisfactory progress toward meeting goals but has not attained plan of care goals, and the goals cannot be addressed at a lower level of care; (iii) the individual is not making progress, and the plan of care has been modified to identify more effective interventions; or (iv) there are current indications that the individual requires this level of treatment to maintain level of functioning as evidenced by failure to achieve goals identified for therapeutic visits or stays in a nontreatment residential setting or in a lower level of residential treatment.

(d) There is a written, up-to-date discharge plan that (i) identifies the custodial parent or custodial caregiver at discharge; (ii) identifies the school the individual will attend at discharge, if applicable; (iii) includes individualized education program (IEP) and FAPT recommendations, if necessary; (iv) outlines the aftercare treatment plan (discharge to another residential level of care is not an acceptable discharge goal); and (v) lists barriers to community reintegration and progress made on resolving these barriers since last review.

(e) The active plan of care includes structure for combined treatment services and activities to ensure the attainment of therapeutic mental health goals as identified in the plan of care. Combined treatment services reinforce and practice skills learned in individual, group, and family therapy such as community integration skills, coping skills, family living and health awareness skills, interpersonal skills, and stress management skills. Combined treatment services may occur in group settings, in one-on-one interactions, or in the home setting during a therapeutic pass. In addition to the combined treatment services, the child or adolescent must also receive psychotherapy services, care coordination, family-based discharge planning, and locality-based transition activities. The child or adolescent shall receive intensive family interventions at least twice per month, although it is recommended that the intensive family interventions be provided at a frequency of one family therapy session per week. Family involvement begins immediately upon admission to therapeutic group home. If the minimum requirement cannot be met, the reasons must be reported, and continued efforts to involve family members must also be documented. Other family members or supportive adults may be included as indicated in the plan of care.

(f) Less restrictive treatment options have been considered but cannot yet meet the individual's treatment needs. There is sufficient current clinical documentation or evidence to show that therapeutic group home level of care continues to be the least restrictive level of care that can meet the individual's mental health treatment needs.

(4) Discharge shall occur if any of the following applies: (i) the level of functioning has improved with respect to the goals outlined in the plan of care, and the individual can reasonably be expected to maintain these gains at a lower level of treatment; (ii) the individual no longer benefits from service as evidenced by absence of progress toward plan of care goals for a period of 60 days; or (iii) other less intensive services may achieve stabilization.

d. The following clinical activities shall be required for each therapeutic group home resident:

(1) An assessment be performed by an LMHP, LMHP-R, LMHP-RP, or LMHP-S.

(2) A face-to-face evaluation shall be performed by an LMHP, LMHP-R, LMHP-RP, or LMHP-S within 30 calendar days prior to admission with a documented DSM-5 or ICD-10 diagnosis.

(3) A certificate of need shall be completed by an independent certification team according to the requirements of subdivision D 4 of this section. Recertification shall occur at least every 60 calendar days

by an LMHP, LMHP-R, LMHP-RP, or LMHP-S acting within his scope of practice.

(4) An IPOC that is specific to the individual's unique treatment needs and acuity levels. The IPOC shall be completed on the day of admission by an LMHP, LMHP-R, LMHP-RP, or LMHP-S and shall be signed by the LMHP, LMHP-R, LMHP-RP, or LMHP-S and the individual and a family member or legally authorized representative. The IPOC shall include all of the following:

(a) Individual and family strengths and personal traits that would facilitate recovery and opportunities to develop motivational strategies and treatment alliance;

(b) Diagnoses, symptoms, complaints, and complications indicating the need for admission;

(c) A description of the functional level of the individual;

(d) Treatment objectives with short-term and long-term goals;

(e) Orders for medications, psychiatric, medical, dental, and any special health care needs whether or not provided in the facilities, treatments, restorative and rehabilitative services, activities, therapies, therapeutic passes, social services, community integration, diet, and special procedures recommended for the health and safety of the individual;

(f) Plans for continuing care, including review and modification to the plan of care; and

(g) Plans for discharge.

(5) A CIPOC shall be completed no later than 14 calendar days after admission. The CIPOC shall meet all of the following criteria:

(a) Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the individual's situation and shall reflect the need for therapeutic group home care;

(b) Be based on input from school, home, other health care providers, FAPT if necessary, the individual, and the family or legal guardian;

(c) Shall state treatment objectives that include measurable short-term and long-term goals and objectives, with target dates for achievement;

(d) Prescribe an integrated program of therapies, activities, and experiences designed to meet the treatment objectives related to the diagnosis; and

(e) Include a comprehensive discharge plan with necessary, clinically appropriate community services to ensure continuity of care upon discharge with the individual's family, school, and community.

(6) The CIPOC shall be reviewed, signed, and dated every 30 calendar days by the LMHP, LMHP-R, LMHP-RP, or LMHP-S and the individual or a family member or primary caregiver. Updates shall be signed and dated by the LMHP, LMHP-R, LMHP-RP, or LMHP-S and the individual or a family member or legally authorized representative. The review shall include all of the following:

(a) The individual's response to the services provided;

(b) Recommended changes in the plan as indicated by the individual's overall response to the CIPOC interventions; and

(c) Determinations regarding whether the services being provided continue to be required.

(7) Crisis management, clinical assessment, and individualized therapy shall be provided to address both behavioral health and substance use disorder needs as indicated in the plan of care to address intermittent crises and challenges within the therapeutic group home setting or community settings as defined in the plan of care and to avoid a higher level of care.

(8) Care coordination shall be provided with medical, educational, and other behavioral health providers and other entities involved in the care and discharge planning for the individual as included in the plan of care.

(9) Weekly individual therapy shall be provided in the therapeutic group home, or other settings as appropriate for the individual's needs, by an LMHP, LMHP-R, LMHP-RP, or LMHP-S, which shall be documented in progress notes in accordance with the requirements in 12VAC30-60-61.

(10) Weekly (or more frequently if clinically indicated) group therapy shall be provided by an LMHP, LMHP-R, LMHP-RP, or LMHP-S, which shall be documented in progress notes in accordance with the requirements in 12VAC30-60-61 and as planned and documented in the plan of care.

(11) Family treatment shall be provided as clinically indicated, provided by an LMHP, LMHP-R, LMHP-RP, or LMHP-S, and documented in progress notes in accordance with the requirements in 12VAC30-60-61 and as planned and documented in the plan of care.

(12) Family engagement activities shall be provided in addition to family therapy or counseling. Family engagement activities shall be provided at least weekly as outlined in the plan of care, and daily communication with the family or legally authorized representative shall be part of the family engagement strategies in the plan of

care. For each service authorization period when family engagement is not possible, the therapeutic group home shall identify and document the specific barriers to the individual's engagement with the individual's family or legally authorized representatives. The therapeutic group home shall document on a weekly basis the reasons why family engagement is not occurring as required. The therapeutic group home shall document alternative family engagement strategies to be used as part of the interventions in the plan of care and request approval of the revised plan of care by DMAS. When family engagement is not possible, the therapeutic group home shall collaborate with DMAS on a weekly basis to develop individualized family engagement strategies and document the revised strategies in the plan of care.

(13) Therapeutic passes shall be provided as clinically indicated in the plan of care and as paired with facility-based and community-based interventions to promote discharge planning, community integration, and family engagement activities.

(a) The provider shall document how the family was prepared for the therapeutic pass to include a review of the plan of care goals and objectives being addressed by the planned interventions and the safety and crisis plan in effect during the therapeutic pass.

(b) If a facility staff member does not accompany the individual on the therapeutic pass and the therapeutic pass exceeds 24 hours, the provider shall make daily contacts with the family and be available 24 hours per day to address concerns, incidents, or crises that may arise during the pass.

(c) Contact with the family shall occur within seven calendar days of the therapeutic pass to discuss the accomplishments and challenges of the therapeutic pass along with an update on progress toward plan of care goals and any necessary changes to the plan of care.

(d) Twenty-four therapeutic passes shall be permitted per individual, per admission, without authorization as approved by the treating LMHP and documented in the plan of care. Additional therapeutic passes shall require service authorization. Any unauthorized therapeutic passes shall result in retraction for those days of service.

(14) Discharge planning shall begin at admission and continue throughout the individual's stay at the therapeutic group home. The family or guardian, the community services board (CSB), the family assessment and planning team (FAPT) case manager, and the DMAS contracted care manager shall be involved in treatment planning and shall identify the anticipated needs of the individual and family upon discharge and available services in the community. Prior to discharge, the therapeutic group home shall submit an active and viable discharge plan to the DMAS contractor for review. Once the DMAS contractor approves the discharge plan, the provider shall begin actively collaborating with the family or legally authorized representative and the treatment team to identify behavioral health and medical providers and schedule appointments for service-specific provider intakes as needed. The therapeutic group home shall request permission from the parent or legally authorized representative to share treatment information with these providers and shall share information pursuant to a valid release. The therapeutic group home shall request information from post-discharge providers to establish that the planning of pending services and transition planning activities has begun, shall establish that the individual has been enrolled in school, and shall provide individualized education program recommendations to the school if necessary. The therapeutic group home shall inform the DMAS contractor of all scheduled appointments within 30 calendar days of discharge and shall notify the DMAS contractor within one business day of the individual's discharge date from the therapeutic group home.

(15) Room and board costs shall not be reimbursed. Facilities that only provide independent living services or nonclinical services that do not meet the requirements of this subsection are not ~~reimbursed~~ eligible for reimbursement. ~~DMAS shall reimburse only for services provided in facilities or programs with no more than 16 beds.~~

~~(4) These residential~~ (16) Therapeutic group home services providers ~~must~~ shall 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)~~ (17) Individuals shall be discharged from this service when treatment goals are met or 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.~~ (18) Services that are based upon incomplete, missing, or outdated service-

specific provider intakes or ~~ISPs~~ plans of care shall be denied reimbursement. ~~Requirements for intakes and ISPs are set out in 12VAC30-60-61.~~

~~(9) These~~ (19) Therapeutic group home services may only be rendered by and within the scope of practice of an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, a QMHP-E, or a QPPMH as defined in 12VAC35-105-20.

~~(10)~~ (20) The ~~facility/group~~ psychiatric residential treatment facility or therapeutic group home shall coordinate necessary services and discharge planning with other providers as medically and clinically necessary. Documentation of this care coordination shall be maintained by the ~~facility/group~~ facility or group home in the individual's record. The documentation shall include who was contacted, when the contact occurred, ~~and~~ what information was transmitted, and recommended next steps.

(21) Failure to perform any of the items described in this subsection shall result in a retraction of the per diem for each day of noncompliance.

3. PRTF services are a 24-hour, supervised, clinically and medically necessary out-of-home program designed to provide necessary support and address mental health, behavioral, substance use, cognitive, or other treatment needs of an individual younger than 21 years of age in order to prevent or minimize the need for more inpatient treatment. Active treatment and comprehensive discharge planning shall begin prior to admission. In order to be covered for individuals younger than 21 years of age, these services shall (i) meet DMAS-approved psychiatric medical necessity criteria or be approved as an EPSDT service based upon a diagnosis made by an LMHP, LMHP-R, LMHP-RP, or LMHP-S who is practicing within the scope of his license and (ii) be reflected in provider records and on the provider's claims for services by recognized diagnosis codes that support and are consistent with the requested professional services.

a. PRTF services shall be covered for the purpose of diagnosis and treatment of mental health and behavioral disorders when such services are rendered by a psychiatric facility that is not a hospital and is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Families and Children, or by any other accrediting organization with comparable standards that is recognized by the state.

b. Providers of PRTF services shall be licensed by DBHDS.

c. PRTF 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 service authorized, and the treatment must meet DMAS requirements for clinical necessity.

d. The PRTF 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 PRTF services at the earliest possible time. The PRTF services benefit shall include services provided under arrangement furnished by Medicaid enrolled providers other than the PRTF, as long as the PRTF (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 PRTF. 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.

e. PRTFs, 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) nonemergency transportation services; and (x) emergency services.

f. PRTF services shall include assessment and reassessment; room and board; daily supervision; combined treatment services; individual, family, and group therapy; care coordination; interventions; general or special education; medical treatment (including medication, coordination of necessary medical services, and 24-hour onsite nursing); specialty services; and discharge planning that meets the medical and clinical needs of the individual.

g. Medical necessity criteria for admission to a PRTF. The following requirements for severity of need and

intensity and quality of service shall be met to satisfy the medical necessity criteria for admission:

(1) Severity of need required for admission. The following criteria shall be met to satisfy the criteria for severity of need:

(a) There is clinical evidence that the individual has a DSM-5 disorder that is amenable to active psychiatric treatment.

(b) There is a high degree of potential of the condition leading to acute psychiatric hospitalization in the absence of residential treatment.

(c) Either (i) there is clinical evidence that the individual would be a risk to self or others if the individual were not in a PRTF or (ii) as a result of the individual's mental disorder, there is an inability for the individual to adequately care for his own physical needs, and caretakers, guardians, or family members are unable to safely fulfill these needs, representing potential serious harm to self.

(d) The individual requires supervision seven days per week, 24 hours per day to develop skills necessary for daily living; to assist with planning and arranging access to a range of educational, therapeutic, and aftercare services; and to develop the adaptive and functional behavior that will allow the individual to live outside of a PRTF setting.

(e) The individual's current living environment does not provide the support and access to therapeutic services needed.

(f) The individual is medically stable and does not require the 24-hour medical or nursing monitoring or procedures provided in a hospital level of care.

(2) Intensity and quality of service necessary for admission. The following criteria shall be met to satisfy the criteria for intensity and quality of service:

(a) The evaluation and assignment of a DSM-5 diagnosis must result from a face-to-face psychiatric evaluation.

(b) The program provides supervision seven days per week, 24 hours per day to assist with the development of skills necessary for daily living; to assist with planning and arranging access to a range of educational, therapeutic, and aftercare services; and to assist with the development of the adaptive and functional behavior that will allow the individual to live outside of a PRTF setting.

(c) An individualized plan of active psychiatric treatment and residential living support is provided in a timely manner. This treatment must be medically monitored, with 24-hour medical availability and 24-hour nursing services availability. This plan includes (i) at least once-a-week psychiatric reassessments; (ii) intensive family or support system involvement occurring at least once per week or valid reasons identified as to why such a plan is not clinically appropriate or feasible; (iii) psychotropic medications, when used, are to be used with specific target symptoms identified; (iv) evaluation for current medical problems; (v) evaluation for concomitant substance use issues; and (vi) linkage or coordination with the individual's community resources, including the local school division and FAPT case manager, as appropriate, with the goal of returning the individual to his regular social environment as soon as possible, unless contraindicated. School contact should address an individualized educational plan as appropriate.

(d) A urine drug screen is considered at the time of admission, when progress is not occurring, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction. After a positive screen, additional random screens are considered and referral to a substance use disorder provider is considered.

(3) Criteria for continued stay. The following criteria shall be met to satisfy the criteria for continued stay:

(a) Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following: (i) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs); (ii) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs); or (iii) that disposition planning or attempts at therapeutic reentry into the community have resulted in or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued PRTF treatment. Subjective opinions without objective clinical information or evidence are not sufficient to meet severity of need based on justifying the expectation that there would be a decompensation.

(b) There is evidence of objective, measurable, and time-limited therapeutic clinical goals that must be met before the individual can return to a new or previous living situation. There is evidence that attempts are being made to secure timely access to treatment resources and housing in anticipation of discharge, with alternative housing contingency plans also being addressed.

(c) There is evidence that the plan of care is focused on the alleviation of psychiatric symptoms and precipitating psychosocial stressors that are interfering with the individual's ability to return to a less-intensive level of care.

(d) The current or revised plan of care can be reasonably expected to bring about significant improvement in the

problems meeting the criteria in subdivision 3 c (3) (a) of this subsection, and this is documented in weekly progress notes written and signed by the provider.

(e) There is evidence of intensive family or support system involvement occurring at least once per week, unless there is an identified valid reason why it is not clinically appropriate or feasible.

(f) A discharge plan is formulated that is directly linked to the behaviors or symptoms that resulted in admission and begins to identify appropriate post-PRTF resources including the local school division and FAPT case manager as appropriate.

(g) All applicable elements in admission-intensity and quality of service criteria are applied as related to assessment and treatment if clinically relevant and appropriate.

(4) Discharge criteria. Discharge shall occur if any of the following applies: (i) the level of functioning has improved with respect to the goals outlined in the plan of care, and the individual can reasonably be expected to maintain these gains at a lower level of treatment; (ii) the individual no longer benefits from service as evidenced by absence of progress toward plan of care goals for a period of 30 days; or (iii) other less intensive services may achieve stabilization.

h. The following clinical activities shall be required for each PRTF resident:

(1) A face-to-face assessment shall be performed by an LMHP, LMHP-R, LMHP-RS, or LMHP-S within 30 calendar days prior to admission and weekly thereafter and shall document a DSM-5 or ICD-10 diagnosis.

(2) A certificate of need shall be completed by an independent certification team according to the requirements of 12VAC30-50-130 D 4. Recertification shall occur at least every 30 calendar days by a physician acting within his scope of practice.

(3) The initial plan of care (IPOC) shall be completed within 24 hours of admission by the treatment team. The IPOC shall include:

(a) Individual and family strengths and personal traits that would facilitate recovery and opportunities to develop motivational strategies and treatment alliance;

(b) Diagnoses, symptoms, complaints, and complications indicating the need for admission;

(c) A description of the functional level of the individual;

(d) Treatment objectives with short-term and long-term goals;

(e) Any orders for medications, psychiatric, medical, dental, and any special health care needs, whether or not provided in the facility; education or special education; treatments; interventions; and restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the individual;

(f) Plans for continuing care, including review and modification to the plan of care;

(g) Plans for discharge; and

(h) Signature and date by the individual, parent, or legally authorized representative, a physician, and treatment team members.

(4) The CIPOC shall be completed and signed no later than 14 calendar days after admission by the treatment team. The PRTF shall request authorizations from families to release confidential information to collect information from medical and behavioral health treatment providers, schools, FAPT, social services, court services, and other relevant parties. This information shall be used when considering changes and updating the CIPOC. The CIPOC shall meet all of the following criteria:

(a) Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the individual's situation and must reflect the need for PRTF care;

(b) Be developed by an interdisciplinary team of physicians and other personnel specified in subdivision 3 d 4 of this subsection who are employed by or provide services to the individual in the facility in consultation with the individual, family member, or legally authorized representative, or appropriate others into whose care the individual will be released after discharge;

(c) Shall state treatment objectives that shall include measurable, evidence-based, and short-term and long-term goals and objectives; family engagement activities; and the design of community-based aftercare with target dates for achievement;

(d) Prescribe an integrated program of therapies, interventions, activities, and experiences designed to meet the treatment objectives related to the individual and family treatment needs; and

(e) Describe comprehensive transition plans and coordination of current care and post-discharge plans with related community services to ensure continuity of care upon discharge with the recipient's family, school, and community.

(5) The CIPOC shall be reviewed every 30 calendar days by the team specified in subdivision 3 d 4 of this subsection to determine that services being provided are or were required from a PRTF and to recommend

changes in the plan as indicated by the individual's overall adjustment during the time away from home. The CIPOC shall include the signature and date from the individual, parent, or legally authorized representative, a physician, and treatment team members.

(6) Individual therapy shall be provided three times per week (or more frequently based upon the individual's needs) provided by an LMHP, LMHP-R, LMHP-RP, or LMHP-S and shall be documented in the plan of care and progress notes in accordance with the requirements in this subsection and 12VAC30-60-61.

(7) Group therapy shall be provided as clinically indicated by an LMHP, LMHP-R, LMHP-RP, or LMHP-S and shall be documented in the plan of care and progress notes in accordance with the requirements in this subsection.

(8) Family therapy shall be provided as clinically indicated by an LMHP, LMHP-R, LMHP-RP, or LMHP-S and shall be documented in the plan of care and progress notes in accordance with the individual and family or legally authorized representative's goals and the requirements in this subsection.

(9) Family engagement shall be provided in addition to family therapy or counseling. Family engagement shall be provided at least weekly as outlined in the plan of care and daily communication with the treatment team representative and the treatment team representative and the family or legally authorized representative shall be part of the family engagement strategies in the plan of care. For each service authorization period when family engagement is not possible, the PRTF shall identify and document the specific barriers to the individual's engagement with his family or legally authorized representatives. The PRTF shall document on a weekly basis the reasons that family engagement is not occurring as required. The PRTF shall document alternate family engagement strategies to be used as part of the interventions in the plan of care and request approval of the revised plan of care by DMAS. When family engagement is not possible, the PRTF shall collaborate with DMAS on a weekly basis to develop individualized family engagement strategies and document the revised strategies in the plan of care.

(10) Three interventions shall be provided per 24-hour period including nights and weekends. Family engagement activities are considered to be an intervention and shall occur based on the treatment and visitation goals and scheduling needs of the family or legally authorized representative. Interventions shall be documented on a progress note and shall be outlined in and aligned with the treatment goals and objectives in the plan of care. Any deviation from the plan of care shall be documented along with a clinical or medical justification for the deviation based on the needs of the individual.

(11) Therapeutic passes shall be provided as clinically indicated in the plan of care and as paired with community-based and facility-based interventions to promote discharge planning, community integration, and family engagement. Therapeutic passes include activities as listed in subdivision 2 d (13) of this section. Twenty-four therapeutic passes shall be permitted per individual, per admission, without authorization as approved by the treating physician and documented in the plan of care. Additional therapeutic passes shall require service authorization from DMAS. Any unauthorized therapeutic passes not approved by the provider or DMAS shall result in retraction for those days of service.

(12) Discharge planning shall begin at admission and continue throughout the individual's placement at the PRTF. The parent or legally authorized representative, the community services board (CSB), the family assessment planning team (FAPT) case manager, if appropriate, and the DMAS contracted care manager shall be involved in treatment planning and shall identify the anticipated needs of the individual and family upon discharge and identify the available services in the community. Prior to discharge, the PRTF shall submit an active discharge plan to the DMAS contractor for review. Once the DMAS contractor approves the discharge plan, the provider shall begin collaborating with the parent or legally authorized representative and the treatment team to identify behavioral health and medical providers and schedule appointments for service-specific provider intakes as needed. The PRTF shall request written permission from the parent or legally authorized representative to share treatment information with these providers and shall share information pursuant to a valid release. The PRTF shall request information from post-discharge providers to establish that the planning of services and activities has begun, shall establish that the individual has been enrolled in school, and shall provide individualized education program recommendations to the school if necessary. The PRTF shall inform the DMAS contractor of all scheduled appointments within 30 calendar days of discharge and shall notify the DMAS contractor within one business day of the individual's discharge date from the PRTF.

(13) Failure to perform any of the items as described in subdivisions 3 h (1) through 3 h (12) of this subsection up until the discharge of the individual shall result in a retraction of the per diem and all other contracted and coordinated service payments for each day of noncompliance.

i. The team developing the CIPOC shall meet the following requirements:

(1) At least one member of the team must have expertise in pediatric behavioral health. Based on education and experience, preferably including competence in child or adolescent psychiatry, the team must be capable of all of the following: assessing the individual's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities; assessing the potential resources of the individual's family or legally authorized representative; setting treatment objectives; and prescribing therapeutic modalities to achieve the CIPOC's objectives.

(2) The team shall include one of the following:

(a) A board-eligible or board-certified psychiatrist;

(b) A licensed clinical psychologist and a physician licensed to practice medicine or osteopathy; or

(c) A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases and a licensed clinical psychologist.

(3) The team shall also include one of the following: an LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP.

4. Requirements for independent certification teams applicable to both therapeutic group homes and PRTFs:

a. The independent certification team shall certify the need for PRTF or therapeutic group home services and issue a certificate of need document within the process and timeliness standards as approved by DMAS under contractual agreement with the DMAS contractor.

b. The independent certification team shall be approved by DMAS through a memorandum of understanding with a locality or be approved under contractual agreement with the DMAS contractor. The team shall initiate and coordinate referral to the family assessment and planning team (FAPT) as defined in §§ 2.2-5207 and 2.2-5208 of the Code of Virginia to facilitate care coordination and for consideration of educational coverage and other supports not covered by DMAS.

c. The independent certification team shall assess the individual's and family's strengths and needs in addition to diagnoses, behaviors, and symptoms that indicate the need for behavioral health treatment and also consider whether local resources and community-based care are sufficient to meet the individual's treatment needs, as presented within the previous 30 calendar days, within the least restrictive environment.

d. The LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP, as part of the independent certification team, shall meet with an individual and the individual's parent or legally authorized representative within two business days from a request to assess the individual's needs and begin the process to certify the need for an out-of-home placement.

e. The independent certification team shall meet with an individual and the individual's parent or legally authorized representative within 10 business days from a request to certify the need for an out-of-home placement.

f. The independent certification team shall assess the treatment needs of the individual to issue a certificate of need (CON) for the most appropriate medically necessary services. The certification shall include the dated signature and credentials for each of the team members who rendered the certification. Referring or treatment providers shall not actively participate during the certification process but may provide supporting clinical documentation to the certification team.

g. The CON shall be effective for 30 calendar days prior to admission.

h. The independent certification team shall provide the completed CON to the facility within one calendar day of completing the CON.

i. The individual and the individual's parent or legally authorized representative shall have the right to freedom of choice of service providers.

j. If the individual or the individual's parent or legally authorized representative disagrees with the independent certification team's recommendation, the parent or legally authorized representative may appeal the recommendation in accordance with 12VAC30-110.

k. If the LMHP, as part of the independent certification team, determines that the individual is in immediate need of treatment, the LMHP shall refer the individual to an appropriate Medicaid-enrolled crisis intervention provider, crisis stabilization provider, or inpatient psychiatric provider in accordance with 12VAC30-50-226 or shall refer the individual for emergency admission to a PRTF or therapeutic group home under subdivision 4 m of this subsection and shall also alert the individual's managed care organization.

l. For individuals who are already eligible for Medicaid at the time of admission, the independent certification team shall be a DMAS-authorized contractor with competence in the diagnosis and treatment of mental illness, preferably in child psychiatry, and have knowledge of the individual's situation and service availability in the individual's local service area. The team shall be composed of at least one physician and one LMHP, including LMHP-S, LMHP-R, and LMHP-RP. An individual's parent or legally authorized representative shall be included in the certification process.

m. For emergency admissions, an assessment must be made by the team responsible for the comprehensive individual plan of care (CIPOC). Reimbursement shall only occur when a certificate of need is issued by the team responsible for the CIPOC within 14 calendar days after admission. The certification shall cover any period of time after admission and before claims are made for reimbursement by Medicaid. After processing an emergency admission, the therapeutic group home, PRTF, or institution for mental diseases (IMD) shall notify the DMAS contractor within five calendar days of the individual's status as being under the care of the facility.

n. For all individuals who apply and become eligible for Medicaid while an inpatient in a facility or program, the certification team shall refer the case to the DMAS contractor for referral to the local FAPT to facilitate care coordination and consideration of educational coverage and other supports not covered by DMAS.

o. For individuals who apply and become eligible for Medicaid while an inpatient in the facility or program, the certification shall be made by the team responsible for the CIPOC and shall cover any period of time before the application for Medicaid eligibility for which claims are made for reimbursement by Medicaid. Upon the individual's enrollment into the Medicaid program, the therapeutic group home, PRTF, or IMD shall notify the DMAS contractor of the individual's status as being under the care of the facility within five calendar days of the individual becoming eligible for Medicaid benefits.

5. Service authorization requirements applicable to both therapeutic group homes and PRTFs:

a. Authorization shall be required and shall be conducted by DMAS using medical necessity criteria specified in this subsection.

b. An individual shall have a valid psychiatric diagnosis and meet the medical necessity criteria as defined in this subsection to satisfy the criteria for admission. The diagnosis shall be current, as documented within the past 12 months. If a current diagnosis is not available, the individual will require a mental health evaluation prior to admission by an LMHP affiliated with the independent certification team to establish a diagnosis and recommend and coordinate referral to the available treatment options.

c. At authorization, an initial length of stay shall be agreed upon by the individual and parent or legally authorized representative with the treating provider, and the treating provider shall be responsible for evaluating and documenting evidence of treatment progress, assessing the need for ongoing out-of-home placement, and obtaining authorization for continued stay.

d. Information that is required to obtain authorization for these services shall include:

(1) A completed state-designated uniform assessment instrument approved by DMAS;

(2) A certificate of need completed by an independent certification team specifying all of the following:

(a) The ambulatory care and Medicaid or FAPT-funded services available in the community do not meet the specific treatment needs of the individual;

(b) Alternative community-based care was not successful;

(c) Proper treatment of the individual's psychiatric condition requires services in a 24-hour supervised setting under the direction of a physician; and

(d) The services can reasonably be expected to improve the individual's condition or prevent further regression so that a more intensive level of care will not be needed;

(3) Diagnosis as defined in the DSM-5 and based on (i) an evaluation by a psychiatrist or LMHP that has been completed within 30 calendar days of admission or (ii) a diagnosis confirmed in writing by an LMHP after review of a previous evaluation completed within one year of admission;

(4) A description of the individual's behavior during the seven calendar days immediately prior to admission;

(5) A description of alternate placements and community mental health and rehabilitation services and traditional behavioral health services pursued and attempted and the outcomes of each service;

(6) The individual's level of functioning and clinical stability;

(7) The level of family involvement and supports available; and

(8) The initial plan of care (IPOC).

6. Continued stay criteria requirements applicable to both therapeutic group homes and PRTFs. For a continued stay authorization or a reauthorization to occur, the individual shall meet the medical necessity criteria as defined in this subsection to satisfy the criteria for continuing care. The length of the authorized stay shall be determined by DMAS. A current plan of care and a current (within 30 calendar days) summary of progress related to the goals and objectives of the plan of care shall be submitted to DMAS for continuation of the service. The service provider shall also submit:

a. A state uniform assessment instrument, completed no more than 30 business days prior to the date of submission;

b. Documentation that the required services have been provided as defined in the plan of care;

c. Current (within the last 14 calendar days) information on progress related to the achievement of all treatment and discharge-related goals; and

d. A description of the individual's continued impairment and treatment needs, problem behaviors, family engagement activities, community-based discharge planning and care coordination, and need for a residential level of care.

7. EPSDT services requirements applicable to therapeutic group homes and PRTFs. Service limits may be exceeded based on medical necessity for individuals eligible for EPSDT. EPSDT services may involve service modalities not available to other individuals, such as applied behavioral analysis and neuro-rehabilitative services. Individualized services to address specific clinical needs identified in an EPSDT screening shall require authorization by a DMAS contractor. In unique EPSDT cases, DMAS may authorize specialized services beyond the standard therapeutic group home or PRTF medical necessity criteria and program requirements, as medically and clinically indicated to ensure the most appropriate treatment is available to each individual. Treating service providers authorized to deliver medically necessary EPSDT services in therapeutic group homes and PRTFs on behalf of a Medicaid-enrolled individual shall adhere to the individualized interventions and evidence-based progress measurement criteria described in the plan of care and approved for reimbursement by DMAS. All documentation, independent certification team, family engagement activity, therapeutic pass, and discharge planning requirements shall apply to cases approved as EPSDT PRTF or therapeutic group home service.

8. Inpatient psychiatric services shall be covered for individuals younger than 21 years of age 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 meet the requirements set forth in subdivision 7 of this subsection.

a. Inpatient psychiatric services shall be provided under the direction of a physician.

b. Inpatient psychiatric services shall be provided by (i) a psychiatric hospital that undergoes a state survey to determine whether the hospital meets the requirements for participation in Medicare as a psychiatric hospital as specified in 42 CFR 482.60 or is accredited by a national organization whose psychiatric hospital accrediting program has been approved by the Centers for Medicare and Medicaid Services (CMS); or (ii) a hospital with an inpatient psychiatric program that undergoes a state survey to determine whether the hospital meets the requirements for participation in Medicare as a hospital, as specified in 42 CFR part 482 or is accredited by a national accrediting organization whose hospital accrediting program has been approved by CMS.

c. Inpatient psychiatric 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.

d. PRTF 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 42 CFR 441.151 (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 service authorized and the treatment must meet DMAS requirements for clinical necessity.

e. The inpatient psychiatric benefit for individuals younger than 21 years of age shall include services that are provided 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 individual's discharge from inpatient status at the earliest possible time. The inpatient psychiatric 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 inpatient psychiatric facility who is licensed to prescribe drugs shall be considered the referral.

f. State freestanding psychiatric hospitals shall arrange for, maintain records of, and ensure that physicians order pharmacy services and emergency services. Private freestanding psychiatric hospitals shall arrange for, maintain records of, and ensure that physicians order the following 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) nonemergency transportation services; and (viii) emergency services. (Emergency services means the same as is set forth in 12VAC30-50-310 B.)

~~f.~~ E. Mental health family support partners.

~~(1)~~ 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)~~ 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)~~ 3. Documentation of required activities shall be required as set forth in 12VAC30-130-5200 A, C, and E through J.

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

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

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

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

~~(6)~~ 6. Individuals 18 ~~through~~, 19, and 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)~~ 7. To qualify for continued mental health family support partners, 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)~~ 8. Discharge criteria from mental health family support partners shall be the same as set forth in 12VAC30-130-5180 E.

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

~~(10)~~ 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)~~ 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)~~ 12. The PRS shall be employed by or have a contractual relationship with the enrolled provider licensed for one of the following:

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

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

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

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

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

~~(f)~~ f. Outpatient psychiatric services provider.

~~(g)~~ 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)~~ 13. Only the licensed and enrolled provider as referenced in subdivision ~~5 f (12)~~ 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)~~ 14. Supervision of the PRS shall meet the requirements set forth in 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.~~ F. 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.~~ G. Addiction and recovery treatment services shall be covered under EPSDT consistent with 12VAC30-130-5000 et seq.

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

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

~~a.~~ 1. 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.~~ 2. 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.~~ 3. 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~~ F. 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)~~ a. Initial and periodic service-specific provider intake as defined in 12VAC30-60-61 ~~H~~ F;

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

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

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

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

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

~~(7)~~ g. Care coordination.

~~C.~~ J. 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~~,~~ and 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~~ administration or 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 or developmental 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~~ professional develops a written plan for meeting the needs of the ~~child~~ individual, 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~~ Individuals 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~~ an individual'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~~ an individual 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~~ individual is receiving a Medicaid-covered service under the IEP. Transportation shall be listed in the ~~child's~~ individual's IEP. ~~Children~~ Individuals 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~~ an individual'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~~ individual 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~~ an individual is receiving additional therapy outside of the school, that there will be coordination of services to avoid duplication of service.

~~D.~~ K. 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~~ board or 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~~ the Department of Health Professions in the guidance document entitled ~~Human Services and Related Fields Approved Degrees/Experience, issued March 12, 2013, revised May 3, 2013.~~ Approved Degrees in Human Services and Related Fields for QMHP Registration, adopted November 3, 2017, revised February 9, 2018.

"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~~ parent or 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~~ the individual's 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 the term is defined in 12VAC35-105-20, including a "QMHP-trainee" as defined by the Department of Health Professions.

"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~~ 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, and 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 a 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~~ DMAS contractor: (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 years of age 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)~~ (PRTF) 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 of age 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, and 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

therapeutic 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~~ Therapeutic 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 psychiatric 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 of age 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, 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 <u>of age</u> 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, 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 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.

DOCUMENTS INCORPORATED BY REFERENCE (12VAC30-50)

Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, DSM-5, 2013, American Psychiatric Association

Length of Stay by Diagnosis and Operation, Southern Region, 1996, HCIA, Inc.

Guidelines for Perinatal Care, 4th Edition, August 1997, American Academy of Pediatrics and the American College of Obstetricians and Gynecologists

Virginia Supplemental Drug Rebate Agreement Contract and Addenda

Office Reference Manual (Smiles for Children), prepared by DMAS' Dental Benefits Administrator, copyright 2010, dated March 13, 2014 (http://www.dmas.virginia.gov/Content_atchs/dnt/VA_SFC_ORM_140313.pdf)

Patient Placement Criteria for the Treatment of Substance-Related Disorders ASAM PPC-2R, Second Edition, copyright 2001, American Society of Addiction Medicine

~~Human Services and Related Fields Approved Degrees/Experience, Department of Behavioral Health and Developmental Services (rev. 5/13)~~

Approved Degrees in Human Services and Related Fields for QMHP Registration, adopted on November 3, 2017, revised on February 9, 2018

12VAC30-60-5. Applicability of utilization review requirements.

A. These utilization requirements shall apply to all Medicaid covered services unless otherwise specified.

B. Some Medicaid covered services require an approved service authorization prior to service delivery in order for reimbursement to occur.

1. To obtain service authorization, all providers' information supplied to the Department of Medical Assistance Services (DMAS)~~, service authorization contractor, or the behavioral health service authorization contractor~~ or its contractor shall be fully substantiated throughout individuals' medical records.

2. Providers shall be required to maintain documentation detailing all relevant information about the Medicaid individuals who are in ~~providers'~~ the provider's care. Such documentation shall fully disclose the extent of services provided in order to support ~~providers'~~ the provider's claims for reimbursement for services rendered. This documentation shall be written, signed, and dated at the time the services are rendered ~~unless specified otherwise~~.

C. DMAS, or its ~~designee~~ contractor, shall perform reviews of the utilization of all Medicaid covered services pursuant to 42 CFR 440.260 and 42 CFR Part 456.

D. DMAS shall recover expenditures made for covered services when providers' documentation does not comport with standards specified in all applicable regulations.

E. Providers who are determined not to be in compliance with DMAS requirements shall be subject to 12VAC30-80-130 for the repayment of those overpayments to DMAS.

F. Utilization review requirements specific to community mental health services and residential treatment services, including therapeutic group homes and psychiatric residential treatment facilities (PRTFs), as set out in 12VAC30-50-130 and 12VAC30-50-226, shall be as follows:

1. To apply to be reimbursed as a Medicaid provider, the required Department of Behavioral Health and Developmental Services (DBHDS) license shall be either a full, annual, triennial, or conditional license. Providers must be enrolled with DMAS or ~~the BHSA~~ its contractor to be reimbursed. Once a health care entity has been enrolled as a provider, it shall maintain, and update periodically as DMAS or its contractor requires, a current Provider Enrollment Agreement for each Medicaid service that the provider offers.

2. Health care entities with provisional licenses shall not be reimbursed as Medicaid providers of community mental health services.

3. Payments shall not be permitted to health care entities that either hold provisional licenses or fail to enter into a ~~Medicaid Provider Enrollment Agreement~~ provider contract with DMAS or its contractor for a service prior to rendering that service.

4. ~~The behavioral health service authorization contractor~~ DMAS or its contractor shall apply 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. Services that fail to meet medical necessity criteria shall be denied service authorization.

5. For purposes of Medicaid reimbursement for services provided by staff in residency, the following terms shall be used after their signatures to indicate such status:

a. An LMHP-R shall use the term "Resident" after his signature.

b. An LMHP-RP shall use the term "Resident in Psychology" after his signature.

c. An LMHP-S shall use the term "Supervisee in Social Work" after his signature.

12VAC30-60-50. Utilization control: Intermediate ~~Care Facilities~~ care facilities for ~~the Mentally Retarded (ICF/MR)~~ persons with intellectual and developmental disabilities and ~~Institutions~~ institutions for ~~Mental Disease (IMD)~~ mental disease.

A. "Institution for mental disease" or "IMD" means the same as that term is defined in § 1905(i) of the Social Security Act.

B. With respect to each Medicaid-eligible resident in an ~~ICF/MR~~ intermediate care facility for persons with intellectual and developmental disabilities (ICF/ID) or an IMD in Virginia, a written plan of care must be developed prior to admission to or authorization of benefits in such facility, and a regular program of independent professional review (including a medical evaluation) shall be completed periodically for such services. The purpose of the review is to determine: the adequacy of the services available to meet ~~his~~ the resident's current health needs and promote ~~his~~ the resident's maximum physical well being; the necessity and desirability of ~~his~~ the resident's continued placement in the facility; and the feasibility of meeting ~~his~~ the resident's health care needs through alternative institutional or noninstitutional services. Long-term care of residents in such facilities will be provided in accordance with federal law that is based on the resident's medical and social needs and requirements.

~~B.~~ C. With respect to each ~~ICF/MR~~ ICF/ID or IMD, periodic ~~on-site~~ onsite inspections of the care being provided to each person receiving medical assistance, by one or more independent professional review teams (composed of a physician or registered nurse and other appropriate health and social service personnel), shall be conducted. The review shall include, with respect to each recipient, a determination of the adequacy of the services available to meet ~~his~~ the resident's current health needs and promote ~~his~~ the resident's maximum physical well-being, the necessity and desirability of continued placement in the facility, and the feasibility of meeting ~~his~~ the resident's health care needs through alternative institutional or noninstitutional services. Full reports shall be made to the state agency by the review team of the findings of each inspection, together with any recommendations.

~~C.~~ D. In order for reimbursement to be made to a facility for ~~the mentally retarded~~ persons with intellectual and developmental disabilities, the resident must meet criteria for placement in such facility as described in 12VAC30-60-360 and the facility must provide active treatment for ~~mental retardation~~ intellectual or developmental disabilities.

~~D.~~ E. In each case for which payment for nursing facility services for ~~the mentally retarded~~ persons with intellectual or developmental disabilities or institution for mental disease services is made under the State Plan:

1. ~~A physician must certify for each applicant or recipient that inpatient care is needed in a facility for the mentally~~

~~retarded or an institution for mental disease.~~ A certificate of need shall be completed by an independent certification team according to the requirements of 12VAC30-50-130 D 5. Recertification shall occur at least every 60 calendar days by a physician, or by a physician assistant or nurse practitioner acting within their scope of practice as defined by state law and under the supervision of a physician. The certification must be made at the time of admission or, if an individual applies for assistance while in the facility, before the Medicaid agency authorizes payment; and

2. A physician, or physician assistant or nurse practitioner acting within the scope of the practice as defined by state law and under the supervision of a physician, must recertify for each applicant at least every ~~365~~ 60 calendar days that services are needed in a facility for ~~the mentally retarded~~ persons with intellectual and developmental disabilities or an institution for mental disease.

~~E.~~ F. When a resident no longer meets criteria for facilities for ~~the mentally retarded~~ persons with intellectual and developmental disabilities or for an institution for mental disease, or no longer requires active treatment in a facility for ~~the mentally retarded~~ persons with intellectual and developmental disabilities then the resident ~~must~~ shall be discharged.

~~F.~~ G. All services provided in an ~~IMD and in an ICF/MR~~ ICF/ID shall be provided in accordance with guidelines found in the Virginia Medicaid Nursing Home Manual.

H. All services provided in an IMD shall be provided with the applicable provider agreement and all documents referenced therein.

I. Psychiatric services in IMDs shall only be covered for eligible individuals younger than 21 years of age.

J. IMD services provided without service authorization from DMAS or its contractor shall not be covered.

K. Absence of any of the required IMD documentation shall result in denial or retraction of reimbursement.

L. In each case for which payment for IMD services is made under the State Plan:

1. A physician shall certify at the time of admission, or at the time the IMD is notified of an individual's retroactive eligibility status, that the individual requires or required inpatient services in an IMD consistent with 42 CFR 456.160.

2. The physician, or physician assistant or nurse practitioner acting within the scope of practice as defined by state law and under the supervision of a physician, shall recertify at least every 60 calendar days that the individual continues to require inpatient services in an IMD.

3. Before admission to an IMD or before authorization for payment, the attending physician or staff physician shall perform a medical evaluation of the individual, and appropriate personnel shall complete a psychiatric and social evaluation as described in 42 CFR 456.170.

4. Before admission to an IMD or before authorization for payment, the attending physician or staff physician shall establish a written plan of care for each individual as described in 42 CFR 441.155 and 42 CFR 456.180.

M. It shall be documented that the individual requiring admission to an IMD who is younger than 21 years of age, that treatment is medically necessary, and that the necessity was identified as a result of an independent certification of need team review. Required documentation shall include the following:

1. Diagnosis, as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition 2013, American Psychiatric Association, and based on an evaluation by a psychiatrist completed within 30 calendar days of admission or if the diagnosis is confirmed, in writing, by a previous evaluation completed within one year within admission.

2. A certification of the need for services as defined in 42 CFR 441.152 by an interdisciplinary team meeting the requirements of 42 CFR 441.153 or 42 CFR 441.156 and the Psychiatric Treatment of Minors Act (§ 16.1-335 et seq. of the Code of Virginia).

N. The use of seclusion and restraint in an IMD shall be in accordance with 42 CFR 483.350 through 42 CFR 483.376. Each use of a seclusion or restraint, as defined in 42 CFR 483.350 through 42 CFR 483.376, shall be reported by the service provider to DMAS or its contractor within one calendar day of the incident.

12VAC30-60-61. Services related to the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT); community mental health and behavioral therapy services for children.

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

"At risk" means one or more of the following: (i) within the two weeks before the intake, the individual shall be screened by an LMHP for escalating behaviors that have put either the individual or others at immediate risk of physical injury; (ii) the ~~parent/guardian~~ parent or guardian is unable to manage the individual's mental, behavioral, or emotional problems in the home and is actively, within the past two to four weeks, seeking an out-of-home placement; (iii) a representative of either a juvenile justice agency, a department of social services (either the state agency or local agency), a community services board/behavioral health authority, the Department of Education, or an LMHP, as defined in 12VAC35-105-20, and who is neither an employee of nor

consultant to the intensive in-home (IIH) services or therapeutic day treatment (TDT) provider, has recommended an out-of-home placement absent an immediate change of behaviors and when unsuccessful mental health services are evident; (iv) the individual has a history of unsuccessful services (either crisis intervention, crisis stabilization, outpatient psychotherapy, outpatient substance abuse services, or mental health support) within the past 30 calendar days; or (v) the treatment team or family assessment planning team (FAPT) recommends IIH services or TDT for an individual currently who is either: (a) transitioning out of psychiatric residential treatment facility ~~Level C~~ (PRTF) services, (b) transitioning out of a therapeutic group home ~~Level A or B services~~, (c) transitioning out of acute psychiatric hospitalization, or (d) transitioning between foster homes, mental health case management, crisis intervention, crisis stabilization, outpatient psychotherapy, or outpatient substance abuse services.

"Failed services" or "unsuccessful services" means, as measured by ongoing behavioral, mental, or physical distress, that the services did not treat or resolve the individual's mental health or behavioral issues.

"Individual" means the Medicaid-eligible person receiving these services and for the purpose of this section includes children from birth up to 12 years of age ~~or~~ and adolescents ages 12 through 20 years.

"Licensed assistant behavior analyst" means a person who has met the licensing requirements of 18VAC85-150 and holds a valid license issued by the Department of Health Professions.

"Licensed behavior analyst" means a person who has met the licensing requirements of 18VAC85-150 and holds a valid license issued by the Department of Health Professions.

"New service" means a community mental health rehabilitation service for which the individual does not have a current service authorization in effect as of July 17, 2011.

"Out-of-home placement" means placement in one or more of the following: (i) ~~either a Level A or Level B~~ therapeutic group home; (ii) regular foster home if the individual is currently residing with ~~his~~ the individual's biological family and, due to his behavior problems, is at risk of being placed in the custody of the local department of social services; (iii) treatment foster care if the individual is currently residing with ~~his~~ the individual's biological family or a regular foster care family and, due to the individual's behavioral problems, is at risk of removal to a higher level of care; (iv) ~~Level C~~ psychiatric residential treatment facility; (v) emergency shelter for the individual only due either to his mental health or behavior or both; (vi) psychiatric hospitalization; or (vii) juvenile justice system or incarceration.

"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 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 plan of care. 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 required to deliver the service. The content of each progress note shall corroborate the time or units billed. Progress notes shall be documented for each service that is billed.

"Service-specific provider intake" means the evaluation that is conducted according to the Department of Medical Assistance Services (DMAS) intake definition set out in 12VAC30-50-130.

B. Utilization review requirements for all services in this section.

1. The services described in this section shall be rendered consistent with the definitions, service limits, and requirements described in this section and in 12VAC30-50-130.

2. Providers shall be required to refund payments made by Medicaid if they fail to maintain adequate documentation to support billed activities.

3. Individual service plans (ISPs) shall meet all of the requirements set forth in 12VAC30-60-143 B 7.

C. Utilization review of intensive in-home (IIH) services for children and adolescents.

1. The service definition for intensive in-home (IIH) services is contained in 12VAC30-50-130.

2. Individuals qualifying for this service shall 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 to be authorized for these services:

a. Have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or out-of-home placement because of conflicts with family or community.

b. Exhibit such inappropriate behavior that documented, repeated interventions by the mental health, social services or judicial system are or have been necessary.

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

3. Prior to admission, an appropriate service-specific provider intake, as defined in 12VAC30-50-130, shall be conducted by the licensed mental health professional (LMHP), LMHP-supervisee, LMHP-resident, or LMHP-RP, documenting the individual's diagnosis and describing how service needs can best be met through intervention provided typically but not solely in the individual's residence. The service-specific provider intake shall describe how the individual's clinical needs put the individual at risk of out-of-home placement and shall be conducted face-to-face in the individual's residence. Claims for services that are based upon service-specific provider intakes that are incomplete, outdated (more than 12 months old), or missing shall not be reimbursed.

4. An individual service plan (ISP) shall be fully completed, signed, and dated by either an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, or a QMHP-E and the individual and individual's ~~parent/guardian~~ parent or guardian within 30 calendar days of initiation of services. The ISP shall meet all of the requirements as defined in 12VAC30-50-226.

5. DMAS shall not reimburse for dates of services in which the progress notes are not individualized and child-specific. Duplicated progress notes shall not constitute the required child-specific individualized progress notes. Each progress note shall demonstrate unique differences particular to the individual's circumstances, treatment, and progress. Claim payments shall be retracted for services that are supported by documentation that does not demonstrate unique differences particular to the individual.

6. Services shall be directed toward the treatment of the eligible individual and delivered primarily in the family's residence with the individual present. As clinically indicated, the services may be rendered in the community if there is documentation, on that date of service, of the necessity of providing services in the community. The documentation shall describe how the alternative community service location supports the identified clinical needs of the individual and describe how it facilitates the implementation of the ISP. For services provided outside of the home, there shall be documentation reflecting therapeutic treatment as set forth in the ISP provided for that date of service in the appropriately signed and dated progress notes.

7. These services shall be provided when the clinical needs of the individual put ~~him~~ the individual at risk for out-of-home placement, as these terms are defined in this section:

a. When services that are far more intensive than outpatient clinic care are required to stabilize the individual in the family situation~~,~~; or

b. When the individual's residence as the setting for services is more likely to be successful than a clinic.

The service-specific provider intake shall describe how the individual meets either subdivision 7 a or 7 b of this ~~subdivision 7~~ subsection.

8. Services shall not be provided if the individual is no longer a resident of the home.

9. Services shall also be used to facilitate the transition to home from an out-of-home placement when services more intensive than outpatient clinic care are required for the transition to be successful. The individual and responsible ~~parent/guardian~~ parent or guardian shall be available and in agreement to participate in the transition.

10. At least one ~~parent/legal~~ parent or legal guardian or responsible adult with whom the individual is living must be willing to participate in the intensive in-home services with the goal of keeping the individual with the family. In the instance of this service, a responsible adult shall be an adult who lives in the same household with the child and is responsible for engaging in therapy and service-related activities to benefit the individual.

11. The enrolled provider shall be licensed by the Department of Behavioral Health and Developmental Services (DBHDS) as a provider of intensive in-home services. The provider shall also have a provider enrollment agreement with DMAS or its contractor in effect prior to the delivery of this service that indicates that the provider will offer intensive in-home services.

12. Services must only be provided by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, QMHP-C, or QMHP-E. Reimbursement shall not be provided for such services when they have been rendered by a QPPMH as defined in 12VAC35-105-20.

13. The billing unit for intensive in-home service shall be one hour. Although the pattern of service delivery may vary, intensive in-home services is an intensive service provided to individuals for whom there is an ISP in effect which demonstrates the need for a minimum of three hours a week of intensive in-home service, and includes a plan for service provision of a minimum of three hours of service delivery per ~~individual/family~~ individual or family per week in the initial phase of treatment. It is expected that the pattern of service provision may show more intensive services and more frequent contact with the individual and family initially with a lessening or tapering off of intensity toward the latter weeks of service. Service plans shall incorporate an individualized discharge plan

that describes transition from intensive in-home to less intensive or nonhome based services.

14. The ISP, as defined in 12VAC30-50-226, shall be updated as the individual's needs and progress changes and signed by either the parent or legal guardian and the individual. Documentation shall be provided if the individual, who is a minor child, is unable or unwilling to sign the ISP. If there is a lapse in services that is greater than 31 consecutive calendar days without any communications from family ~~members/legal~~ members or legal guardian or the individual with the provider, the provider shall discharge the individual. If the individual continues to need services, then a new ~~intake/admission~~ intake or admission shall be documented and a new service authorization shall be required.

15. The provider shall ensure that the maximum staff-to-caseload ratio fully meets the needs of the individual.

16. If an individual receiving services is also receiving case management services pursuant to 12VAC30-50-420 or 12VAC30-50-430, the provider shall contact the case manager and provide notification of the provision of services. In addition, the provider shall send monthly updates to the case manager on the individual's status. A discharge summary shall be sent to the case manager within 30 calendar days of the service discontinuation date. Providers and case managers who are using the same electronic health record for the individual shall meet requirements for delivery of the notification, monthly updates, and discharge summary upon entry of the information in the electronic health records.

17. Emergency assistance shall be available 24 hours per day, seven days a week.

18. Providers shall comply with DMAS marketing requirements at 12VAC30-130-2000. Providers that DMAS determines violate these marketing requirements shall be terminated as a Medicaid provider pursuant to 12VAC30-130-2000 E.

19. The provider shall determine who the primary care provider is and, upon receiving written consent from the individual or guardian, shall inform ~~him~~ the primary care provider of the individual's receipt of IIH services. The documentation shall include who was contacted, when the contact occurred, and what information was transmitted.

D. Utilization review of therapeutic day treatment for children and adolescents.

1. The service definition for therapeutic day treatment (TDT) for children and adolescents is contained in 12VAC30-50-130.

2. Therapeutic day treatment is appropriate for children and adolescents who meet one of the following criteria:

a. Children and adolescents who require year-round treatment in order to sustain behavior or emotional gains.

b. Children and adolescents whose behavior and emotional problems are so severe they cannot be handled in self-contained or resource emotionally disturbed (ED) classrooms without:

(1) This programming during the school day; or

(2) This programming to supplement the school day or school year.

c. Children and adolescents who would otherwise be placed on homebound instruction because of severe emotional/behavior problems that interfere with learning.

d. Children and adolescents who (i) have deficits in social skills, peer relations or dealing with authority; (ii) are hyperactive; (iii) have poor impulse control; or (iv) are extremely depressed or marginally connected with reality.

e. Children in preschool enrichment and early intervention programs when the children's ~~emotional/behavioral~~ emotional or behavioral problems are so severe that ~~they~~ the children cannot function in these programs without additional services.

3. The service-specific provider intake shall document the individual's behavior and describe how the individual meets these specific service criteria in subdivision 2 of this subsection.

4. Prior to admission to this service, a service-specific provider intake shall be conducted by the LMHP as defined in 12VAC35-105-20.

5. An ISP shall be fully completed, signed, and dated by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, or QMHP-E and by the individual or the ~~parent/guardian~~ parent or guardian within 30 calendar days of initiation of services and shall meet all requirements of an ISP as defined in 12VAC30-50-226. Individual progress notes shall be required for each contact with the individual and shall meet all of the requirements as defined in ~~12VAC30-50-130~~ this section.

6. Such services shall not duplicate those services provided by the school.

7. 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. Individuals shall meet at least two of the following criteria on a continuing or intermittent basis:

a. Have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are

at risk of hospitalization or out-of-home placement because of conflicts with family or community.

b. Exhibit such inappropriate behavior that documented, repeated interventions by the mental health, social services, or judicial system are or have been necessary.

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

8. The enrolled provider of therapeutic day treatment for child and adolescent services shall be licensed by DBHDS to provide day support services. The provider shall also have a provider enrollment agreement in effect with DMAS prior to the delivery of this service that indicates that the provider offers therapeutic day treatment services for children and adolescents.

9. Services shall be provided by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, QMHP-C, or QMHP-E.

10. The minimum staff-to-individual ratio as defined by DBHDS licensing requirements shall ensure that adequate staff is available to meet the needs of the individual identified on the ISP.

11. The program shall operate a minimum of two hours per day and may offer flexible program hours (i.e., before or after school or during the summer). One unit of service shall be defined as a minimum of two hours but less than three hours in a given day. Two units of service shall be defined as a minimum of three but less than five hours in a given day. Three units of service shall be defined as five or more hours of service in a given day.

12. Time required for academic instruction when no treatment activity is going on shall not be included in the billing unit.

13. Services shall be provided following a service-specific provider intake that is conducted by an LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP. An LMHP, LMHP-supervisee, or LMHP-resident shall make and document the diagnosis. The service-specific provider intake shall include the elements as defined in 12VAC30-50-130.

14. If an individual receiving services is also receiving case management services pursuant to 12VAC30-50-420 or 12VAC30-50-430, the provider shall collaborate with the case manager and provide notification of the provision of services. In addition, the provider shall send monthly updates to the case manager on the individual's status. A discharge summary shall be sent to the case manager within 30 calendar days of the service discontinuation date. Providers and case managers using the same electronic health record for the individual shall meet requirements for delivery of the notification, monthly updates, and discharge summary upon entry of this documentation into the electronic health record.

15. The provider shall determine who the primary care provider is and, upon receiving written consent from the individual or ~~parent/legal~~ the individual's parent or legal guardian, shall inform the primary care provider of the ~~child's~~ the individual's receipt of community mental health rehabilitative services. The documentation shall include who was contacted, when the contact occurred, and what information was transmitted. The ~~parent/legal~~ parent or legal guardian shall be required to give written consent that this provider has permission to inform the primary care provider of the child's or adolescent's receipt of community mental health rehabilitative services.

16. Providers shall comply with DMAS marketing requirements as set out in 12VAC30-130-2000. Providers that DMAS determines have violated these marketing requirements shall be terminated as a Medicaid provider pursuant to 12VAC30-130-2000 E.

17. If there is a lapse in services greater than 31 consecutive calendar days, the provider shall discharge the individual. If the individual continues to need services, a new ~~intake/admission~~ intake or admission documentation shall be prepared and a new service authorization shall be required.

~~E. Utilization review of community-based services for children and adolescents younger than 21 years of age (Level A).~~

~~1. The staff ratio must be at least one to six during the day and at least one to 10 between 11 p.m. and 7 a.m. The program director supervising the program/group home must be, at minimum, a QMHP-C or QMHP-E (as defined in 12VAC35-105-20). The program director must be employed full-time.~~

~~2. In order for Medicaid reimbursement to be approved, at least 50% of the provider's direct care staff at the group home must meet DBHDS paraprofessional staff criteria, defined in 12VAC35-105-20.~~

~~3. Authorization is required for Medicaid reimbursement. All community-based services for children and adolescents younger than 21 (Level A) require authorization prior to reimbursement for these services. Reimbursement shall not be made for this service when other less intensive services may achieve stabilization.~~

~~4. Services must be provided in accordance with an individual service plan (ISP), which must be fully completed within 30 days of authorization for Medicaid reimbursement.~~

~~5. Prior to admission, a service specific provider intake shall be conducted according to DMAS specifications described in 12VAC30-50-130.~~

~~6. Such service-specific provider intakes shall be performed by an LMHP, an LMHP-supervisee, LMHP-resident, or LMHP-RP.~~

~~7. If an individual receiving community-based services for children and adolescents younger than 21 years of age (Level A) is also receiving case management services, the provider shall collaborate with the case manager by notifying the case manager of the provision of Level A services and shall send monthly updates on the individual's progress. When the individual is discharged from Level A services, a discharge summary shall be sent to the case manager within 30 days of the service discontinuation date. Providers and case managers who are using the same electronic health record for the individual shall meet requirements for the delivery of the notification, monthly updates, and discharge summary upon entry of this documentation into the electronic health record.~~

~~F.~~ E. Utilization review of therapeutic ~~behavioral services~~ group home for children and adolescents younger than 21 years of age ~~(Level B)~~.

1. The staff ratio must be ~~at least one to four during the day and at least one to eight between 11 p.m. and 7 a.m.~~ approved by the Office of Licensure at the Department of Behavioral Health and Developmental Services. The clinical director ~~must~~ shall be a licensed mental health professional. The caseload of the clinical director must not exceed 16 individuals including all sites for which the same clinical director is responsible.

2. The program director ~~must~~ shall be full time and ~~be a QMHP-C or QMHP-E with a bachelor's degree and at least one year's clinical experience~~ meet the requirements for a program director as defined in 12VAC35-46-350.

3. For Medicaid reimbursement to be approved, at least 50% of the provider's direct care staff at the therapeutic group home shall meet DBHDS ~~paraprofessional staff~~ qualified paraprofessional in mental health (QPPMH) criteria, as defined in 12VAC35-105-20. The ~~program/group~~ therapeutic group home ~~must~~ shall coordinate services with other providers.

4. All therapeutic ~~behavioral~~ group home services ~~(Level B)~~ shall be authorized prior to reimbursement for these services. Services rendered without such prior authorization shall not be covered.

5. Services must be provided in accordance with ~~an ISP~~ a comprehensive individual plan of care as defined in 12VAC30-50-130, which shall be fully completed within 30 calendar days of authorization for Medicaid reimbursement.

6. Prior to admission, ~~a service-specific provider intake~~ an assessment shall be performed using all elements specified by DMAS in 12VAC30-50-130.

7. Such ~~service-specific provider intakes~~ assessments shall be performed by an LMHP, an LMHP-supervisee, LMHP-resident, or LMHP-RP.

8. If an individual receiving therapeutic ~~behavioral~~ group home services for children and adolescents younger than 21 years of age ~~(Level B)~~ is also receiving case management services, the therapeutic ~~behavioral~~ group home services provider must collaborate with the care coordinator/case manager by notifying him of the provision of ~~Level B~~ therapeutic group home services and the ~~Level B~~ therapeutic group home services provider shall send monthly updates on the individual's treatment status. ~~When the individual is discharged from Level B services, a discharge summary shall be sent to the care coordinator/case manager within 30 days of the discontinuation date.~~

9. The provider shall determine who the primary care provider is and, upon receiving written consent from the individual or ~~parent/legal guardian~~ parent or legally authorized representative, shall inform the primary care provider of the individual's receipt of ~~these Level B~~ therapeutic group home services. The documentation shall include who was contacted, when the contact occurred, and what information was transmitted. If these individuals are children or adolescents, then the ~~parent/legal guardian~~ parent or legally authorized representative shall be required to give written consent that this provider has permission to inform the primary care provider of the individual's receipt of community mental health rehabilitative services.

~~G. Utilization review. Utilization reviews for community-based services for children and adolescents younger than 21 years of age (Level A) and therapeutic behavioral services for children and adolescents younger than 21 years of age (Level B) shall include determinations whether providers meet all DMAS requirements, including compliance with DMAS marketing requirements. Providers that DMAS determines have violated the DMAS marketing requirements shall be terminated as a Medicaid provider pursuant to 12VAC30-130-2000 E.~~

~~H.~~ F. Utilization review of behavioral therapy services for ~~children~~ individuals younger than 21 years of age.

1. In order for Medicaid to cover behavioral therapy services, the provider shall be enrolled with DMAS or its contractor as a Medicaid provider. The provider enrollment agreement shall be in effect prior to the delivery of services for Medicaid reimbursement.

2. Behavioral therapy services shall be covered for individuals younger than 21 years of age when recommended by the individual's primary care provider, 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.

3. Behavioral therapy services require service authorization. Services shall be authorized only when eligibility and medical necessity criteria are met.

4. Prior to treatment, an appropriate service-specific provider intake shall be conducted, documented, signed, and dated by a licensed behavior analyst (LBA), licensed assistant behavior analyst (LABA), LMHP, LMHP-R, LMHP-RP, or LMHP-S, acting within the scope of his practice, documenting the individual's diagnosis (including a description of the behaviors targeted for treatment with their frequency, duration, and intensity) and describing how service needs can best be met through behavioral therapy. The service-specific provider intake shall be conducted face-to-face in the individual's residence with the individual and parent or guardian.

5. The ISP shall be developed upon admission to the service and reviewed within 30 days of admission to the service to ensure that all treatment goals are reflective of the individual's clinical needs and shall describe each treatment goal, targeted behavior, one or more measurable objectives for each targeted behavior, the behavioral modification strategy to be used to manage each targeted behavior, the plan for parent or caregiver training, care coordination, and the measurement and data collection methods to be used for each targeted behavior in the ISP. The ISP as defined in 12VAC30-50-130 shall be fully completed, signed, and dated by an LBA, LABA, LMHP, LMHP-R, LMHP-RP, or LMHP-S. Every three months, the LBA, LABA, LMHP, LMHP-R, LMHP-RP, or LMHP-S shall review the ISP, modify the ISP as appropriate, and update the ISP, and all of these activities shall occur with the individual in a manner in which the individual may participate in the process. The ISP shall be rewritten at least annually.

6. Reimbursement for the initial service-specific provider intake and the initial ISP shall be limited to five hours without service authorization. If additional time is needed to complete these documents, service authorization shall be required.

7. Clinical supervision shall be required for Medicaid reimbursement of behavioral therapy services that are rendered by an LABA, LMHP-R, LMHP-RP, or LMHP-S or unlicensed staff consistent with the scope of practice as described by the applicable Virginia Department of Health Professions regulatory board. Clinical supervision of unlicensed staff shall occur at least weekly. As documented in the individual's medical record, clinical supervision shall include a review of progress notes and data and dialogue with supervised staff about the individual's progress and the effectiveness of the ISP. Clinical supervision shall be documented by, at a minimum, the contemporaneously dated signature of the clinical supervisor.

8. Family training involving the individual's family and significant others to advance the treatment goals of the individual shall be provided when (i) the training with the family member or significant other is for the direct benefit of the individual, (ii) the training is not aimed at addressing the treatment needs of the individual's family or significant others, (iii) the individual is present except when it is clinically appropriate for the individual to be absent in order to advance the individual's treatment goals, and (iv) the training is aligned with the goals of the individual's treatment plan.

9. The following shall not be covered under this service:

a. Screening to identify physical, mental, or developmental conditions that may require evaluation or treatment. Screening is covered as an EPSDT service provided by the primary care provider and is not covered as a behavioral therapy service under this section.

b. Services other than the initial service-specific provider intake that are provided but are not based upon the individual's ISP or linked to a service in the ISP. Time not actively involved in providing services directed by the ISP shall not be reimbursed.

c. Services that are based upon an incomplete, missing, or outdated service-specific provider intake or ISP.

d. Sessions that are conducted for family support, education, recreational, or custodial purposes, including respite or child care.

e. Services that are provided by a provider but are rendered primarily by a relative or guardian who is legally responsible for the individual's care.

f. Services that are provided in a clinic or provider's office without documented justification for the location in the ISP.

g. Services that are provided in the absence of the individual or a parent or other authorized caregiver identified in the ISP with the exception of treatment review processes described in subdivision 12 e of this subsection, care coordination, and clinical supervision.

h. Services provided by a local education agency.

i. Provider travel time.

10. Behavioral therapy services shall not be reimbursed concurrently with community mental health services described in 12VAC30-50-130 ~~B 5~~ C or 12VAC30-50-226, or behavioral, psychological, or psychiatric therapeutic consultation described in 12VAC30-120-756, 12VAC30-120-1000, or 12VAC30-135-320.

11. If the individual is receiving targeted case management services under the ~~Medicaid state plan~~ State Plan (defined in 12VAC30-50-410 through ~~12VAC30-50-491~~ 12VAC30-50-491), the provider shall notify the case manager of the provision of behavioral therapy services unless the parent or guardian requests that the information not be released. In addition, the provider shall send monthly updates to the case manager on the individual's status pursuant to a valid release of information. A discharge summary shall be sent to the case manager within 30 days of the service discontinuation date. A refusal of the parent or guardian to release information shall be documented in the medical record for the date the request was discussed.

12. Other standards to ensure quality of services:

a. Services shall be delivered only by an LBA, LABA, LMHP, LMHP-R, LMHP-RP, LMHP-S, or clinically supervised unlicensed staff consistent with the scope of practice as described by the applicable Virginia Department of Health Professions regulatory board.

b. Individual-specific services shall be directed toward the treatment of the eligible individual and delivered in the family's residence unless an alternative location is justified and documented in the ISP.

c. Individual-specific progress notes shall be created contemporaneously with the service activities and shall document the name and Medicaid number of each individual; the provider's name, signature, and date; and time of service. Documentation shall include activities provided, length of services provided, the individual's reaction to that day's activity, and documentation of the individual's and the parent or caregiver's progress toward achieving each behavioral objective through analysis and reporting of quantifiable behavioral data. Documentation shall be prepared to clearly demonstrate efficacy using baseline and service-related data that shows clinical progress and generalization for the child and family members toward the therapy goals as defined in the service plan.

d. Documentation of all billed services shall include the amount of time or billable units spent to deliver the service and shall be signed and dated on the date of the service by the practitioner rendering the service.

e. Billable time is permitted for the LBA, LABA, LMHP, LMHP-R, LMHP-RP, or LMHP-S to better define behaviors and develop documentation strategies to measure treatment performance and the efficacy of the ISP objectives, provided that these activities are documented in a progress note as described in subdivision 12 c of this subsection.

13. Failure to comply with any of the requirements in 12VAC30-50-130 or in this section shall result in retraction.

DOCUMENTS INCORPORATED BY REFERENCE (12VAC30-60)

Department of Medical Assistance Services Provider Manuals (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManuals):

Virginia Medicaid Nursing Home Manual

Virginia Medicaid Rehabilitation Manual

Virginia Medicaid Hospice Manual

Virginia Medicaid School Division Manual

Development of Special Criteria for the Purposes of Pre-Admission Screening, Medicaid Memo, October 3, 2012, Department of Medical Assistance Services

Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV-TR), copyright 2000, American Psychiatric Association

Patient Placement Criteria for the Treatment of Substance-Related Disorders (ASAM PPC-2R), Second Edition, copyright 2001, American Society on Addiction Medicine, Inc.

Medicaid Special Memo, Subject: New Service Authorization Requirement for an Independent Clinical Assessment for Medicaid and FAMIS Children's Community Mental Health Rehabilitative Services, dated June 16, 2011, Department of Medical Assistance Services

Medicaid Special Memo, Subject: Changes to Children Community Mental Health Rehabilitative Services - Children's Services, July 1, 2010 & September 1, 2010, dated July 23, 2010, Department of Medical Assistance Services

Medicaid Special Memo, Subject: Changes to Community Mental Health Rehabilitative Services - Adult-Oriented Services, July 1, 2010 & September 1, 2010, dated July 23, 2010, Department of Medical Assistance Services

Approved Degrees in Human Services and Related Fields for QMHP Registration, adopted November 3, 2017, revised February 9, 2018

Part XIV
Residential Psychiatric Treatment for Children and Adolescents (Repealed)

12VAC30-130-850. ~~Definitions.~~ (Repealed.)

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

~~"Active treatment" means implementation of a professionally developed and supervised individual plan of care that must be designed to achieve the recipient's discharge from inpatient status at the earliest possible time.~~

~~"Certification" means a statement signed by a physician that inpatient services in a residential treatment facility are or were needed. The certification must be made at the time of admission, or, if an individual applies for assistance while in a mental hospital or residential treatment facility, before the Medicaid agency authorizes payment.~~

~~"Comprehensive individual plan of care" or "CIPOC" means a written plan developed for each recipient in accordance with 12VAC30-130-890 to improve his condition to the extent that inpatient care is no longer necessary.~~

~~"Emergency services" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.~~

~~"Individual" or "individuals" means a child or adolescent younger than 21 years of age who is receiving a service covered under this part of this chapter.~~

~~"Initial plan of care" means a plan of care established at admission, signed by the attending physician or staff physician, that meets the requirements in 12VAC30-130-890.~~

~~"Inpatient psychiatric facility" or "IPF" means a private or state-run freestanding psychiatric hospital or psychiatric residential treatment center.~~

~~"Recertification" means a certification for each applicant or recipient that inpatient services in a residential treatment facility are needed. Recertification must be made at least every 60 days by a physician, or physician assistant or nurse practitioner acting within the scope of practice as defined by state law and under the supervision of a physician.~~

~~"Recipient" or "recipients" means the child or adolescent younger than 21 years of age receiving this covered service.~~

~~"RTC-Level C" means a psychiatric residential treatment facility (Level C).~~

~~"Services provided under arrangement" means services including physician and other health care services that are furnished to children while they are in an IPF that are billed by the arranged practitioners separately from the IPF per diem.~~

12VAC30-130-860. Service coverage; eligible individuals; service certification. (Repealed.)

~~A. Residential treatment programs (Level C) shall be 24-hour, supervised, medically necessary, out-of-home programs designed to provide necessary support and address the special mental health and behavioral needs of a child or adolescent in order to prevent or minimize the need for more intensive inpatient treatment. Services must include, but shall not be limited to, assessment and evaluation, medical treatment (including drugs), individual and group counseling, and family therapy necessary to treat the child.~~

~~B. Residential treatment programs (Level C) shall provide a total, 24 hours per day, specialized form of highly organized, intensive and planned therapeutic interventions that shall be utilized to treat some of the most severe mental, emotional, and behavioral disorders. Residential treatment is a definitive therapeutic modality designed to deliver specified results for a defined group of problems for children or adolescents for whom outpatient day treatment or other less intrusive levels of care are not appropriate, and for whom a protected, structured milieu is medically necessary for an extended period of time.~~

~~C. Therapeutic Behavioral Services for Children and Adolescents under 21 (Level B) and Community-Based Services for Children and Adolescents under 21 (Level A) must be therapeutic services rendered in a residential type setting such as a group home or program that provides structure for daily activities, psychoeducation, therapeutic supervision and mental health care to ensure the attainment of therapeutic mental health goals as identified in the individual service plan (plan of care). The child or adolescent must have a medical 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.~~

~~D. Active treatment shall be required. Residential Treatment, Therapeutic Behavioral and Community-Based Services for Children and Adolescents under age 21 shall be designed to serve the mental health needs of children. In order to be reimbursed for Residential Treatment (Level C), Therapeutic Behavioral Services for Children and Adolescents under 21 (Level B), and Community-Based Services for Children and Adolescents under 21 (Level A), the facility must provide active mental health treatment beginning at admission and it must be related to the recipient's principle diagnosis and admitting symptoms. To the extent that any recipient needs mental health treatment and his needs meet the medical necessity criteria for the service, he will be approved for these services. These services do not include interventions and activities designed only to meet the supportive nonmental health special needs, including but not limited to personal care, habilitation or academic educational needs of the recipients.~~

E. An individual eligible for Residential Treatment Services (Level C) is a recipient under the age of 21 years whose treatment needs cannot be met by ambulatory care resources available in the community, for whom proper treatment of his psychiatric condition requires services on an inpatient basis under the direction of a physician.

An individual eligible for Therapeutic Behavioral Services for Children and Adolescents under 21 (Level B) is a child, under the age of 21 years, for whom proper treatment of his psychiatric condition requires less intensive treatment in a structured, therapeutic residential program under the direction of a Licensed Mental Health Professional.

An individual eligible for Community Based Services for Children and Adolescents under 21 (Level A) is a child, under the age of 21 years, for whom proper treatment of his psychiatric condition requires less intensive treatment in a structured, therapeutic residential program under the direction of a qualified mental health professional. The services for all three levels can reasonably be expected to improve the child's or adolescent's condition or prevent regression so that the services will no longer be needed.

F. In order for Medicaid to reimburse for Residential Treatment (Level C), Therapeutic Behavioral Services for Children and Adolescents under 21 (Level B), and Community Based Services for Children and Adolescents under 21 (Level A), the need for the service must be certified according to the standards and requirements set forth in subdivisions 1 and 2 of this subsection. At least one member of the independent certifying team must have pediatric mental health expertise.

1. For an individual who is already a Medicaid recipient when he is admitted to a facility or program, certification must:

a. Be made by an independent certifying team that includes a licensed physician who:

(1) Has competence in diagnosis and treatment of pediatric mental illness; and

(2) Has knowledge of the recipient's mental health history and current situation.

b. Be signed and dated by a physician and the team.

2. For a recipient who applies for Medicaid while an inpatient in the facility or program, the certification must:

a. Be made by the team responsible for the plan of care;

b. Cover any period of time before the application for Medicaid eligibility for which claims for reimbursement by Medicaid are made; and

c. Be signed and dated by a physician and the team.

12VAC30-130-870. ~~Preauthorization.~~ (Repealed.)

A. Authorization for Residential Treatment (Level C) shall be required within 24 hours of admission and shall be conducted by DMAS or its utilization management contractor using medical necessity criteria specified by DMAS. At preauthorization, an initial length of stay shall be assigned and the residential treatment provider shall be responsible for obtaining authorization for continued stay.

B. DMAS will not pay for admission to or continued stay in residential facilities (Level C) that were not authorized by DMAS.

C. Information that is required in order to obtain admission preauthorization for Medicaid payment shall include:

1. A completed state-designated uniform assessment instrument approved by the department.

2. A certification of the need for this service by the team described in 12VAC30-130-860 that:

a. The ambulatory care resources available in the community do not meet the specific treatment needs of the recipient;

b. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician; and

c. The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will not be needed.

3. Additional required written documentation shall include all of the following:

a. Diagnosis, as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV, effective October 1, 1996), including Axis I (Clinical Disorders), Axis II (Personality Disorders/Mental Retardation, Axis III (General Medical Conditions), Axis IV (Psychosocial and Environmental Problems), and Axis V (Global Assessment of Functioning);

b. A description of the child's behavior during the seven days immediately prior to admission;

c. A description of alternative placements tried or explored and the outcomes of each placement;

d. The child's functional level and clinical stability;

e. The level of family support available; and

f. The initial plan of care as defined and specified at 12VAC30-130-890.

D. Continued stay criteria for Residential Treatment (Level C): information for continued stay authorization (Level C) for Medicaid payment must include:

1. A state uniform assessment instrument, completed no more than 90 days prior to the date of submission;

2. Documentation that the required services are provided as indicated;

3. Current (within the last 30 days) information on progress related to the achievement of treatment goals. The treatment goals must address the reasons for admission, including a description of any new symptoms amenable to treatment;

4. Description of continued impairment, problem behaviors, and need for Residential Treatment level of care.

E. Denial of service may be appealed by the recipient consistent with 12VAC30-110-10 et seq.; denial of reimbursement may be appealed by the provider consistent with the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia).

F. DMAS will not pay for services for Therapeutic Behavioral Services for Children and Adolescents under 21 (Level B), and Community Based Services for Children and Adolescents under 21 (Level A) that are not prior authorized by DMAS.

G. Authorization for Level A and Level B residential treatment shall be required within three business days of admission. Authorization for services shall be based upon the medical necessity criteria described in 12VAC30-50-130. The authorized length of stay must not exceed six months and may be reauthorized. The provider shall be responsible for documenting the need for a continued stay and providing supporting documentation.

H. Information that is required in order to obtain admission authorization for Medicaid payment must include:

1. A current completed state-designated uniform assessment instrument approved by the department. The state-designated uniform assessment instrument must indicate at least two areas of moderate impairment for Level B and two areas of moderate impairment for Level A. A moderate impairment is evidenced by, but not limited to:

a. Frequent conflict in the family setting, for example, credible threats of physical harm.

b. Frequent inability to accept age-appropriate direction and supervision from caretakers, family members, at school, or in the home or community.

c. Severely limited involvement in social support; which means significant avoidance of appropriate social interaction, deterioration of existing relationships, or refusal to participate in therapeutic interventions.

d. Impaired ability to form a trusting relationship with at least one caretaker in the home, school or community.

e. Limited ability to consider the effect of one's inappropriate conduct on others, interactions consistently involving conflict, which may include impulsive or abusive behaviors.

2. A certification of the need for the service by the team described in 12VAC30-130-860 that:

a. The ambulatory care resources available in the community do not meet the specific treatment needs of the child;

b. Proper treatment of the child's psychiatric condition requires services in a community-based residential program; and

c. The services can reasonably be expected to improve the child's condition or prevent regression so that the services will not be needed.

3. Additional required written documentation must include all of the following:

a. Diagnosis, as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV, effective October 1, 1996), including Axis I (Clinical Disorders), Axis II (Personality Disorders/Mental Retardation), Axis III (General Medical Conditions), Axis IV (Psychosocial and Environmental Problems), and Axis V (Global Assessment of Functioning);

b. A description of the child's behavior during the 30 days immediately prior to admission;

c. A description of alternative placements tried or explored and the outcomes of each placement;

d. The child's functional level and clinical stability;

e. The level of family support available; and

f. The initial plan of care as defined and specified at 12VAC30-130-890.

I. Denial of service may be appealed by the child consistent with 12VAC30-110; denial of reimbursement may be appealed by the provider consistent with the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia).

J. Continued stay criteria for Levels A and B:

1. The length of the authorized stay shall be determined by DMAS or its contractor.

2. A current Individual Service Plan (ISP) (plan of care) and a current (within 30 days) summary of progress related to the goals and objectives on the ISP (plan of care) must be submitted for continuation of the service.

3. For reauthorization to occur, the desired outcome or level of functioning has not been restored or improved,

over the time frame outlined in the child's ISP (plan of care) or the child continues to be at risk for relapse based on history or the tenuous nature of the functional gains and use of less intensive services will not achieve stabilization. Any one of the following must apply:

a. The child has achieved initial service plan (plan of care) goals but additional goals are indicated that cannot be met at a lower level of care.

b. The child is making satisfactory progress toward meeting goals but has not attained ISP goals, and the goals cannot be addressed at a lower level of care.

c. The child is not making progress, and the service plan (plan of care) has been modified to identify more effective interventions.

d. There are current indications that the child requires this level of treatment to maintain level of functioning as evidenced by failure to achieve goals identified for therapeutic visits or stays in a nontreatment residential setting or in a lower level of residential treatment.

K. Discharge criteria for Levels A and B.

1. Reimbursement shall not be made for this level of care if either of the following applies:

a. The level of functioning has improved with respect to the goals outlined in the service plan (plan of care) and the child can reasonably be expected to maintain these gains at a lower level of treatment; or

b. The child no longer benefits from service as evidenced by absence of progress toward service plan goals for a period of 60 days.

12VAC30-130-880. ~~Provider qualifications.~~ (Repealed.)

A. Providers must provide all Residential Treatment Services (Level C) as defined within this part and set forth in 42 CFR Part 441 Subpart D.

B. Providers of Residential Treatment Services (Level C) must be:

1. A residential treatment program for children and adolescents licensed by DMHMRSAS that is located in a psychiatric hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations;

2. A residential treatment program for children and adolescents licensed by DMHMRSAS that is located in a psychiatric unit of an acute general hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations; or

3. A psychiatric facility that is (i) accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, the Council on Quality and Leadership in Supports for People with Disabilities, or the Council on Accreditation of Services for Families and Children and (ii) licensed by DMHMRSAS as a residential treatment program for children and adolescents.

C. Providers of Community Based Services for Children and Adolescents under 21 (Level A) must be licensed by the Department of Social Services, Department of Juvenile Justice, or Department of Education under the Standards for Interdepartmental Regulation of Children's Residential Facilities (22VAC42-10).

D. Providers of Therapeutic Behavioral Services (Level B) must be licensed by the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) under the Standards for Interdepartmental Regulation of Children's Residential Facilities (22VAC42-10).

12VAC30-130-890. ~~Plans of care; review of plans of care.~~ (Repealed.)

A. All Medicaid services are subject to utilization review and audit. The absence of any required documentation may result in denial or retraction of any reimbursement.

B. For Residential Treatment Services (Level C) (RTS-Level C), an initial plan of care must be completed at admission and a Comprehensive Individual Plan of Care (CIPOC) must be completed no later than 14 days after admission.

C. Initial plan of care (Level C) must include:

1. Diagnoses, symptoms, complaints, and complications indicating the need for admission;

2. A description of the functional level of the individual;

3. Treatment objectives with short-term and long-term goals;

4. Any orders for medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the individual and a list of services provided under arrangement (see 12VAC30-50-130 for eligible services provided under arrangement) that will be furnished to the individual through the RTC Level C's referral to an employed or a contracted provider of services under arrangement, including the prescribed frequency of treatment and the circumstances under which such treatment shall be sought;

5. Plans for continuing care, including review and modification to the plan of care;

6. Plans for discharge; and

7. Signature and date by the physician.

D. The CIPOC for Level C must meet all of the following criteria:

1. Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the individual's situation and must reflect the need for inpatient psychiatric care;

2. Be developed by an interdisciplinary team of physicians and other personnel specified under subsection G of this section, who are employed by, or provide services to, patients in the facility in consultation with the individual and his parents, legal guardians, or appropriate others in whose care he will be released after discharge;

3. State treatment objectives that must include measurable short-term and long-term goals and objectives, with target dates for achievement;

4. Prescribe an integrated program of therapies, activities, and experiences designed to meet the treatment objectives related to the diagnosis;

5. Include a list of services provided under arrangement (described in 12VAC30-50-130) that will be furnished to the individual through referral to an employee or a contracted provider of services under arrangement, including the prescribed frequency of treatment and the circumstances under which such treatment shall be sought; and

6. Describe comprehensive discharge plans and coordination of inpatient services and post-discharge plans with related community services to ensure continuity of care upon discharge with the individual's family, school, and community.

E. Review of the CIPOC for Level C. The CIPOC must be reviewed every 30 days by the team specified in subsection G of this section to:

1. Determine that services being provided are or were required on an inpatient basis; and

2. Recommend changes in the plan as indicated by the individual's overall adjustment as an inpatient.

F. The development and review of the plan of care for Level C as specified in this section satisfies the facility's utilization control requirements for recertification and establishment and periodic review of the plan of care, as required in 42 CFR 456.160 and 456.180.

G. Team developing the CIPOC for Level C. The following requirements must be met:

1. At least one member of the team must have expertise in pediatric mental health. Based on education and experience, preferably including competence in child psychiatry, the team must be capable of all of the following:

a. Assessing the individual's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities;

b. Assessing the potential resources of the individual's family;

c. Setting treatment objectives; and

d. Prescribing therapeutic modalities to achieve the plan's objectives.

2. The team must include, at a minimum, either:

a. A board-eligible or board-certified psychiatrist;

b. A clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy; or

c. A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master's degree in clinical psychology or who has been certified by the state or by the state psychological association.

3. The team must also include one of the following:

a. A psychiatric social worker;

b. A registered nurse with specialized training or one year's experience in treating mentally ill individuals;

c. An occupational therapist who is licensed, if required by the state, and who has specialized training or one year of experience in treating mentally ill individuals; or

d. A psychologist who has a master's degree in clinical psychology or who has been certified by the state or by the state psychological association.

H. The RTC:Level C shall not receive a per diem reimbursement for any day that:

1. The initial or comprehensive written plan of care fails to include within three business days of the initiation of the service provided under arrangement:

a. The prescribed frequency of treatment of such service, or includes a frequency that was exceeded; or

b. All services that the individual needs while residing at the RTC:Level C and that will be furnished to the individual through the RTC:Level C referral to an employed or contracted provider of services under arrangement;

2. The initial or comprehensive written plan of care fails to list the circumstances under which the service provided under arrangement shall be sought;

3. The referral to the service provided under arrangement was not present in the individual's RTC:Level C record;

4. The service provided under arrangement was not supported in that provider's records by a documented referral from the RTC Level C;

5. The medical records from the provider of services under arrangement (i.e., admission and discharge documents, treatment plans, progress notes, treatment summaries, and documentation of medical results and findings) (i) were not present in the individual's RTC Level C record or had not been requested in writing by the RTC Level C within seven days of discharge from or completion of the service or services provided under arrangement or (ii) had been requested in writing within seven days of discharge from or completion of the service or services provided under arrangement, but not received within 30 days of the request, and not re-requested;

6. The RTC Level C did not have a fully executed contract or employee relationship with an independent provider of services under arrangement in advance of the provision of such services. For emergency services, the RTC Level C shall have a fully executed contract with the emergency services provider prior to submission of the emergency service provider's claim for payment;

7. A physician's order for the service under arrangement is not present in the record; or

8. The service under arrangement is not included in the individual's CIPOC within 30 calendar days of the physician's order.

I. The provider of services under arrangement shall be required to reimburse DMAS for the cost of any such service provided under arrangement that was (i) furnished prior to receiving a referral or (ii) in excess of the amounts in the referral. Providers of services under arrangement shall be required to reimburse DMAS for the cost of any such services provided under arrangement that were rendered in the absence of an employment or contractual relationship.

J. For therapeutic behavioral services for children and adolescents under 21 (Level B), the initial plan of care must be completed at admission by the licensed mental health professional (LMHP) and a CIPOC must be completed by the LMHP no later than 30 days after admission. The assessment must be signed and dated by the LMHP.

K. For community-based services for children and adolescents under 21 (Level A), the initial plan of care must be completed at admission by the QMHP and a CIPOC must be completed by the QMHP no later than 30 days after admission. The individualized plan of care must be signed and dated by the program director.

L. Initial plan of care for Levels A and B must include:

1. Diagnoses, symptoms, complaints, and complications indicating the need for admission;

2. A description of the functional level of the individual;

3. Treatment objectives with short term and long term goals;

4. Any orders for medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the patient;

5. Plans for continuing care, including review and modification to the plan of care; and

6. Plans for discharge.

M. The CIPOC for Levels A and B must meet all of the following criteria:

1. Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the individual's situation and must reflect the need for residential psychiatric care;

2. The CIPOC for both levels must be based on input from school, home, other health care providers, the individual and family (or legal guardian);

3. State treatment objectives that include measurable short-term and long-term goals and objectives, with target dates for achievement;

4. Prescribe an integrated program of therapies, activities, and experiences designed to meet the treatment objectives related to the diagnosis; and

5. Describe comprehensive discharge plans with related community services to ensure continuity of care upon discharge with the individual's family, school, and community.

N. Review of the CIPOC for Levels A and B. The CIPOC must be reviewed, signed, and dated every 30 days by the QMHP for Level A and by the LMHP for Level B. The review must include:

1. The response to services provided;

2. Recommended changes in the plan as indicated by the individual's overall response to the plan of care interventions; and

3. Determinations regarding whether the services being provided continue to be required.

Updates must be signed and dated by the service provider.

VA.R. Doc. No. R17-4495; Filed February 6, 2019, 2:45 p.m.

Proposed Regulation

Title of Regulation: **12VAC30-50. Amount, Duration, and Scope of Medical and Remedial Care Services (amending 12VAC30-50-165).**

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: May 3, 2019.

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

Purpose: As practices evolve and coverage is provided under the State Plan, there are times when it becomes necessary to amend regulations to conform them to best practices and new guidance from the Centers for Medicare and Medicaid Services (CMS) to eliminate areas of confusion. It is expected that these changes will clarify coverage of durable medical equipment (DME) for DME providers and Medicaid beneficiaries, and reduce unnecessary documentation elements for DME providers. Further, the changes will improve coverage by permitting newer and better forms of service delivery that have evolved in recent years and will align Virginia's coverage with recent guidance from CMS for enteral nutrition.

These regulatory changes will improve the health, safety, and welfare of the affected Medicaid individuals by providing care coordination and well-person preventive services.

Substance:

1. Enteral nutrition. Current coverage requires that enteral nutrition be the primary or sole source of nutrition (defined) in order to qualify for coverage. In addition, DME providers must indicate on the certificate of medical necessity (CMN) if the enteral nutrition is covered through Women, Infants, and Children (WIC), a program of the U.S. Department of Agriculture. CMS has provided new, written guidance to Virginia on coverage for enteral nutrition. The guidance includes the elimination of the requirement that such enteral nutrition be the Medicaid beneficiary's primary or sole source of nutrition. The guidance further spells out coverage requirements related to medical foods, over-the-counter products, and dietary restrictions. Lastly, the subsection on enteral nutrition has documentation requirements that are redundant and required of all providers as stated in an earlier subsection. The proposed changes amend the section to update and conform Medicaid coverage of enteral nutrition to guidance from CMS and to reduce redundant language and requirements.

2. Infusion therapy. Current coverage in Virginia defines home infusion therapy as the administration of intravenous fluids, drugs, chemical agents, or nutritional supplements. Best practices for delivering home infusion therapy now include the option for providing such services intravenously (I.V.) or through an implantable pump. The proposed changes amend the section to permit the use of implantable pumps for delivering home infusion therapy.

3. Delivery ticket components. Current coverage requires DME providers to include the Medicaid beneficiary's name and Medicaid number or date of birth on the delivery ticket. Further, DME providers must include the serial numbers or the product numbers of the DME or supplies. The delivery ticket requirements are unnecessary and burdensome to DME providers. The proposed changes amend the delivery ticket requirements to streamline and enhance flexibility and provide an alternative option of using an individual's medical record number.

4. Replacement DME. Currently, the regulation does not identify a process for providing replacement DME to Medicaid beneficiaries who have lost DME or had DME destroyed as a result of a disaster. It has become evident to DMAS that a process should be developed and implemented to ensure quality care and protect the health and safety of Medicaid beneficiaries. The proposed changes amend the section to identify the process and requirements for providing replacement DME to Medicaid beneficiaries who have lost DME or had DME destroyed as a result of a disaster.

Issues: The current coverages do not conform to best practices and processes as required by CMS to ensure quality care and protect the health and safety of Medicaid individuals. The primary advantages to the public, the agency, and the Commonwealth from the proposed amendments include enhanced service delivery to DME beneficiaries and greater consistency between Virginia regulations and current CMS practice. There are no disadvantages to the public or the Commonwealth as a result of these regulatory changes.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. On behalf of the Board of Medical Assistance Services, the Director of the Department of Medical Assistance Services (DMAS) proposes to: 1) eliminate the requirement that

enteral nutrition (EN) be the Medicaid beneficiary's primary or sole source of nutrition in order to cover EN, 2) amend text to clarify that the use of implantable pumps for delivering home infusion therapy is permitted and covered, 3) reduce requirements concerning the delivery ticket, and 4) clarify the process for providing replacement durable medical equipment and supplies (DME) to Medicaid beneficiaries who have lost DME or had DME destroyed as a result of a natural disaster.

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

Estimated Economic Impact.

Enteral Nutrition: EN is defined as "any method of feeding that uses the gastrointestinal tract to deliver part or all of an individual's caloric requirements. Enteral nutrition may include a routine oral diet, the use of liquid supplements, or delivery of part or all of the daily requirements by use of a tube (tube feeding)." EN can be effective in helping prevent malnutrition for patients with a variety of conditions.[1] It has been found to reduce hospital complications, duration of stay, and mortality.[2]

The current regulation requires that EN be the primary or sole source of nutrition in order to qualify for coverage. Pursuant to guidance from the federal Centers for Medicare and Medicaid Services (CMS), the Director proposes to eliminate the requirement that enteral nutrition EN be the Medicaid beneficiary's primary or sole source of nutrition in order to qualify for coverage. DMAS estimates the annual cost of this proposed change to be $2,308,065, half to be paid with state funds and half to be paid with federal funds. As described above, expanding the use of EN can have significant health benefits.

Home Infusion Therapy: The current regulation defines home infusion therapy as the administration of intravenous fluids, drugs, chemical agents, or nutritional supplements. The Director proposes to amend the definition of home infusion therapy to indicate that it can be administered either intravenously or through the use of an implantable pump. In practice, the use of an implantable pump has been covered.[3] Thus, this proposed amendment would effectively just be a clarification for readers of the regulation. Nevertheless, it would be beneficial in that it would reduce the likelihood of confusion over whether implantable pumps are covered.

Delivery Ticket Components: Under the current regulation, DME providers must include the Medicaid beneficiary's name and Medicaid number or date of birth on the delivery ticket. Further, DME providers must include the serial number(s) or the product numbers of the DME or supplies. The Director proposes to: 1) allow DME providers the option of having a unique identifier (e.g., an individual's medical record number) instead of the Medicaid number or date of birth on the ticket, and 2) no longer require serial number(s) or the product numbers on the ticket. This proposal reduces the burden on DME providers.

Replacement DME: The current regulation does not address the process for providing replacement DME to Medicaid beneficiaries who have lost DME or had DME destroyed due to a natural disaster. The Director proposes to add a section to the regulation to identify the process and requirements for providing replacement DME to Medicaid beneficiaries who have lost DME or had DME destroyed due to a natural disaster. According to DMAS, the proposed language matches how this is currently done in practice. However, adding the section would likely be beneficial in that it helps inform Medicaid recipients, Medicaid enrolled providers, and other interested parties who may not be specifically aware of the process and requirements.

Businesses and Entities Affected. The proposed amendments affect the approximate 1,400 Medicaid-enrolled DME providers,[4] and Medicaid recipients. Most providers would qualify as small businesses.

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

Projected Impact on Employment. The proposal to cover EN even when it is not the sole or primary source of nutrition would increase demand for tubing and other supplies associated with EN. There may consequently be a moderate increase in employment at firms that provide these supplies.

Effects on the Use and Value of Private Property. The proposal to cover EN even when it is not the sole or primary source of nutrition would increase demand for tubing and other supplies associated with EN. There may consequently be a moderate increase in the value of firms that provide these supplies.

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 proposals to allow DME providers the option of having a unique identifier instead of the Medicaid number or date of birth on the delivery ticket, and to no longer require serial number(s) or the product numbers, would moderately reduce costs for small DME providers.

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 Thomas D "Enteral Tube Nutrition" Merck Manual February 2017.

[2]See Stroud M, Duncan H, Nightingale J "Guidelines for enteral feeding in adult hospital patients" Gut 2003;52: vii1-vii12.

[3]Source: Department of Medical Assistance Services

[4]Data source: Department of Medical Assistance Services

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 proposed amendments update coverage and documentation requirements for durable medical equipment (DME) by (i) eliminating the requirement that enteral nutrition be the Medicaid beneficiary's primary or sole source of nutrition and redundant language and requirements regarding enteral nutrition, (ii) permitting the use of implantable pumps for delivering home infusion therapy, (iii) streamlining the delivery ticket requirements to enhance flexibility and provide an alternative option of using an individual's medical record number on the ticket, and (iv) identifying the process and requirements for providing replacement DME to Medicaid beneficiaries who have lost DME or had DME destroyed as a result of a disaster.

12VAC30-50-165. Durable medical equipment ~~(DME) and supplies~~ suitable for use in the home.

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

"Affirmative contact" means speaking, either face-to-face or by phone, with either the individual or caregiver in order to ascertain that the DME ~~and supplies are~~ is still needed and appropriate. Such contacts shall be documented in the individual's medical record.

"Certificate of Medical Necessity" or "CMN" means the DMAS-352 form required to be completed and submitted in order for DMAS to provide reimbursement.

"Designated agent" means an entity with whom DMAS has contracted to perform ~~contracted~~ functions such as provider audits and prior authorizations of services.

"DMAS" means the Department of Medical Assistance Services.

"DME provider" means those entities enrolled with DMAS to render DME services.

"Durable medical equipment" or "DME" means medical equipment, supplies, and appliances suitable for use in the home consistent with 42 CFR 440.70(b)(3) that treat a diagnosed condition or assist the individual with functional limitations.

"Enteral nutrition" refers to any method of feeding that uses the gastrointestinal tract to deliver part or all of an individual's caloric requirements. "Enteral nutrition" may include a routine oral diet, the use of liquid supplements, or delivery of part or all of the daily requirements by use of a tube, which is called tube feeding.

"Expendable supply" means an item that is used and then disposed of.

"Frequency of use" means the rate of use by the individual as documented by the number of times per ~~day/week/month~~ day, week, or month, as appropriate, a supply is used by the individual. Frequency of use must be recorded on the face of the CMN in such a way that reflects whether a supply is used by the individual on a daily, weekly, or monthly basis. Frequency of use may be documented on the CMN as a range of the rate of use. By way of example and not limitation, the frequency of use of a supply may be expressed as a range, such as four to six adult diapers per day. However, large ranges shall not be acceptable documentation of frequency of use ~~(for,~~ for example, the range of one to six adult diapers per day shall not be acceptable.~~)~~ The frequency of use provides the justification for the total quantity of supplies ordered on the CMN.

"Functional limitation" means the inability to perform a normal activity.

"Practitioner" means a licensed provider of physician services as defined in 42 CFR 440.50.

"Prior authorization" or "PA" ~~(also "service authorization")~~ means the process of approving either by DMAS or its prior authorization ~~(or service authorization)~~ contractor for the purposes of DMAS reimbursement for the service for the individual before it is rendered or reimbursed.

"Quantity" means the total number of supplies ordered on a monthly basis as reflected on the CMN. The monthly quantity of supplies ordered for the individual shall be dependent upon the individual's frequency of use.

~~"Sole source of nutrition" means that the individual is unable to tolerate (swallow or absorb) any other form of oral nutrition in instances when more than 75% of the individual's daily caloric intake is received from nutritional supplements.~~

B. General requirements and conditions.

1. a. All medically necessary supplies and equipment shall be covered. Unusual amounts, types, and duration of usage must be authorized by DMAS in accordance with published policies and procedures. When determined to be cost effective by DMAS, payment may be made for rental of the equipment in lieu of purchase.

b. No provider shall have a claim of ownership on DME reimbursed by Virginia Medicaid once it has been delivered to the Medicaid individual. Providers shall only be permitted to recover DME, for example, when DMAS determines that it does not fulfill the required medically necessary purpose as set out in the Certificate of Medical Necessity, when there is an error in the ordering practitioner's CMN, or when the equipment was rented.

2. DME providers shall adhere to all applicable federal and state laws and regulations and DMAS policies for DME ~~and supplies~~. DME providers shall comply with all other applicable Virginia laws and regulations requiring licensing, registration, or permitting. Failure to comply with such laws and regulations that are required by ~~such~~ a licensing agency ~~or agencies~~ shall result in denial of coverage for DME ~~or supplies~~.

3. DME ~~products or supplies~~ must be furnished pursuant to a properly completed Certificate of Medical Necessity (CMN) (DMAS-352). In order to obtain Medicaid reimbursement, specific fields of the DMAS-352 form shall be completed as specified in 12VAC30-60-75.

4. DME ~~and supplies~~ shall be ordered by the licensed practitioner and shall be related to medical treatment of the Medicaid individual. The complete DME order shall be recorded on the CMN for Medicaid individuals to receive such services. In the absence of a different effective period determined by DMAS or its designated agent, the CMN shall be valid for a maximum period of six months for Medicaid individuals younger than 21 years of age. In the absence of a different effective period determined by DMAS or its designated agent, the maximum valid time period for CMNs for Medicaid individuals 21 years of age and older shall be 12 months. The validity of the CMN shall terminate when the individual's medical need for the prescribed DME ~~or supplies~~ no longer exists as determined by the licensed practitioner.

5. DME shall be furnished exactly as ordered by the licensed practitioner who signed the CMN. The CMN and any supporting verifiable documentation shall be fully completed, signed, and dated by the licensed practitioner, and in the DME provider's possession within 60 days from the time the ordered DME ~~and supplies are~~ is initially furnished by the DME provider. Each component of the DME ~~items~~ shall be specifically ordered on the CMN by the licensed practitioner.

6. The CMN shall not be changed, altered, or amended after the licensed practitioner has signed it. If the individual's condition indicates that changes in the ordered DME ~~or supplies are~~ is necessary, the DME provider shall obtain a new CMN. All new CMNs shall be signed and dated by the licensed practitioner within 60 days from the time the ordered supplies are furnished by the DME provider.

7. DMAS or its designated agent shall have the authority to determine a different ~~(from those specified above)~~ length of time from those specified in subdivisions 4, 5, and 6 of this subsection that a CMN may be valid based on medical documentation submitted on the CMN. The CMN may be completed by the DME provider or other appropriate health care professionals, but it shall be signed and dated by the licensed practitioner, as specified in subdivision 5 of this subsection. Supporting documentation may be attached to the CMN but the licensed practitioner's entire order for DME ~~and supplies~~ shall be on the CMN.

8. The DME provider shall retain a copy of the CMN and all supporting verifiable documentation on file for ~~DMAS'~~ purposes of the DMAS post payment audit review ~~purposes~~. DME providers shall not create or revise CMNs or supporting documentation for this service after the initiation of the post payment review audit process. Licensed practitioners shall not complete, sign, or date CMNs once the post payment audit review has begun.

9. The DME provider shall be responsible for knowledge of items requiring prior authorization and the limitation on the provision of certain items as described in the Virginia Medicaid Durable Medical Equipment and Supplies Manual, Appendix B. ~~The~~ Appendix B shall be the official listing of all items covered through the Virginia Medicaid DME program and ~~lists~~ list the service limits, items that require prior authorization, billing units, and reimbursement rates.

10. The DME provider shall be required to make affirmative contact with the individual or his caregiver and document the interaction prior to the next month's delivery and prior to the recertification CMN to assure that the appropriate quantity, frequency, and product are provided to the individual.

11. Supporting documentation, added to a completed CMN, shall be allowed to further justify the medical need for DME. Supporting documentation shall not replace the requirement for a properly completed CMN. The dates of the supporting documentation shall coincide with the dates of service on the CMN, and the supporting documentation shall be ~~fully~~ signed and dated by the licensed practitioner.

C. ~~Effective July 1, 2010, the~~ The billing unit for incontinence supplies (such as diapers, pull-ups, and panty liners) shall be by each product. For example, if the

incontinence supply being provided is diapers, the billing unit would be by individual diaper, rather than a case of diapers. Prior authorization shall be required for incontinence supplies provided in quantities greater than the allowable service limit per month.

D. Supplies, equipment, or appliances that are not covered include~~, but shall not be limited to,~~ the following:

1. Space conditioning equipment, such as room humidifiers, air cleaners, and air conditioners;

2. DME ~~and supplies~~ for any hospital or nursing facility resident, except ventilators and associated supplies or specialty beds for the treatment of wounds consistent with DME criteria for nursing facility residents that have been prior approved by ~~the~~ DMAS ~~central office~~ or designated agent;

3. Furniture or appliances not defined as medical equipment (such as blenders, bedside tables, mattresses other than for a hospital bed, pillows, blankets or other bedding, special reading lamps, chairs with special lift seats, hand-held shower devices, exercise bicycles, and bathroom scales);

4. Items that are only for the individual's comfort and convenience or for the convenience of those caring for the individual (e.g., a hospital bed or mattress because the individual does not have a bed; wheelchair trays used as a desk surface); mobility items used in addition to primary assistive mobility aide for ~~caregiver's or individual's~~ the convenience of the individual or his caregiver (e.g., an electric wheelchair plus a manual chair); and cleansing wipes;

5. Prosthesis, except for artificial arms, legs, and their supportive devices, which shall be prior authorized by ~~the~~ DMAS ~~central office~~ or designated agent;

6. Items and services that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member (e.g., dentifrices; toilet articles; shampoos that do not require a licensed practitioner's prescription; dental adhesives; electric toothbrushes; cosmetic items, soaps, and lotions that do not require a licensed practitioner's prescription; sugar and salt substitutes; and support stockings);

7. Orthotics, including braces, diabetic shoe inserts, splints, and supports;

8. Home or vehicle modifications;

9. Items not suitable for or not used primarily in the home setting (e.g., car seats, equipment to be used while at school, etc.);

10. Equipment for which the primary function is vocationally or educationally related (e.g., computers, environmental control devices, speech devices, etc.);

11. Diapers for routine use by children younger than three years of age who have not yet been toilet trained;

12. Equipment or items that are not suitable for use in the home; and

13. Equipment or items that the Medicaid individual or his caregiver is unwilling or unable to use in the home.

E. For coverage of blood glucose meters for pregnant women, refer to 12VAC30-50-510.

F. Coverage of home infusion therapy.

1. Home infusion therapy shall be defined as the ~~intravenous (I.V.)~~ administration of fluids, drugs, chemical agents, or nutritional substances to ~~recipients~~ individuals through intravenous (I.V.) therapy or an implantable pump in the home setting. DMAS shall reimburse for these services, supplies, and drugs on a service day rate methodology established in 12VAC30-80-30. The therapies to be covered under this policy shall be: hydration therapy, chemotherapy, pain management therapy, drug therapy, and total parenteral nutrition (TPN). All the therapies that meet criteria shall be covered and do not require prior authorization. The established service day rate shall reimburse for all services delivered in a single day. There shall be no additional reimbursement for special or extraordinary services. In the event of incompatible drug administration, a separate HCPCS code shall be used to allow for rental of a second infusion pump and purchase of an extra administration tubing. When applicable, this code may be billed in addition to the other service day rate codes. There shall be documentation to support the use of this code on the I.V. Implementation Form. Proper documentation shall include the need for pump administration of the medications ordered, frequency of administration to support that they are ordered simultaneously, and indication of incompatibility.

2. The service day rate payment methodology shall be mandatory for reimbursement of all I.V. therapy services except for the individual who is enrolled in the Technology Assisted Waiver.

3. The following limitations shall apply to this service:

a. This service must be medically necessary to treat an individual's medical condition. The service must be ordered and provided in accordance with accepted medical practice. The service must not be desired solely for the convenience of the individual or the individual's caregiver.

b. In order for Medicaid to reimburse for this service, the individual shall:

(1) Reside in either a private home or a domiciliary care facility, such as an assisted living facility. Because the reimbursement for DME is already provided under institutional reimbursement, individuals in hospitals, nursing facilities, rehabilitation centers, and other institutional settings shall not be covered for this service;

(2) Be under the care of a licensed practitioner who prescribes the home infusion therapy and monitors the progress of the therapy;

(3) Have body sites available for peripheral intravenous catheter or needle placement or have a central venous access; and

(4) Be capable of either self-administering such therapy or have a caregiver who can be adequately trained, is capable of administering the therapy, and is willing to safely and efficiently administer and monitor the home infusion therapy. The caregiver must be willing to and be capable of following appropriate teaching and adequate monitoring. In cases where the individual is incapable of administering or monitoring the prescribed therapy and there is no adequate or trained caregiver, it may be appropriate for a home health agency to administer the therapy.

G. The DME ~~and supply~~ vendor shall provide the equipment and supplies as prescribed by the licensed practitioner on the CMN. Orders shall not be changed unless the vendor obtains a new CMN, which includes the licensed practitioner's signature, prior to ordering the equipment or supplies or providing the equipment or supplies to the individual.

H. Medicaid shall not provide reimbursement to the DME ~~and supply~~ vendor for services that are provided ~~either:~~ (i) prior to the date prescribed by the licensed practitioner; (ii) prior to the date of the delivery; or (iii) when services are not provided in accordance with ~~DMAS'~~ DMAS published regulations and guidance documents. If reimbursement is denied for one or all of these reasons, the DME ~~and supply~~ vendor shall not bill the Medicaid individual for the service that was provided.

I. The following criteria shall be satisfied through the submission of adequate and verifiable documentation on the CMN satisfactory to DMAS. Medically necessary DME ~~and supplies~~ shall be:

1. Ordered by the licensed practitioner on the CMN;

2. A reasonable and necessary part of the individual's treatment plan;

3. Consistent with the individual's diagnosis and medical condition, particularly the functional limitations and symptoms exhibited by the individual;

4. Not furnished solely for the convenience, safety, or restraint of the individual, the family or caregiver, the licensed practitioner, or other licensed practitioner or supplier;

5. Consistent with generally accepted professional medical standards (i.e., not experimental or investigational); and

6. Furnished at a safe, effective, and cost-effective level suitable for use in the individual's home environment.

J. Medical documentation shall provide DMAS or the designated agent with evidence of the individual's DME needs. Medical documentation may be recorded on the CMN or evidenced in the supporting documentation attached to the CMN. The following applies to the medical justification necessary for all DME services regardless of whether prior authorization is required. The documentation is necessary to identify:

1. The medical need for the requested DME;

2. The diagnosis related to the reason for the DME request;

3. The individual's functional limitation and its relationship to the requested DME;

4. How the DME service will treat the individual's medical condition;

5. For expendable supplies, the quantity needed and the medical reason the requested amount is needed;

6. The frequency of use to describe how often the DME is used by the individual;

7. The estimated duration of use of the equipment (rental and purchased);

8. Any other treatment being rendered to the individual relative to the use of DME ~~or supplies~~;

9. How the needs were previously met, identifying changes that have occurred that necessitate the DME;

10. Other alternatives tried or explored and a description of the success or failure of these alternatives;

11. How the DME service is required in the individual's home environment; and

12. The individual's or his caregiver's ability, willingness, and motivation to use the DME.

K. DME provider responsibilities. To receive reimbursement, the DME provider shall, at a minimum, perform the following:

1. Verify the individual's current Medicaid eligibility;

2. Determine whether the ordered ~~item or~~ items are a covered service and require prior authorization;

3. Deliver all ~~of the item or~~ items ordered by the licensed practitioner;

4. Deliver only the quantities ordered by the licensed practitioner on the CMN and prior authorized by DMAS if required;

5. Deliver only the ~~item or~~ items for the periods of service covered by the licensed practitioner's order and prior authorized, if required, by DMAS;

6. Maintain a copy of the licensed practitioner's signed CMN and all verifiable supporting documentation for all DME ~~and supplies~~ ordered;

7. Document and justify the description of services (i.e., labor, repairs, maintenance of equipment);

8. Document and justify the medical necessity, frequency, and duration for all items and supplies as set out in the Medicaid DME guidance documents;

9. Document all DME ~~and supplies~~ provided to an individual in accordance with the licensed practitioner's orders. The delivery ~~ticket/proof~~ ticket or proof of delivery shall document the requirements as stated in subsection L of this section~~.~~; and

10. ~~Documentation~~ Meet documentation requirements for the use of DME billing codes that have Individual Consideration (IC) indicated as the reimbursement fee ~~shall~~ to include a complete description of the ~~item or~~ items, a copy of the ~~supply invoice or~~ supplies invoices or the manufacturer's cost information, and all discounts that were received by the DME provider. Additional information regarding requirements for the IC reimbursement process can be found in the relevant agency guidance document.

L. Proof of delivery.

1. The delivery ticket shall contain the following information:

a. The Medicaid individual's name and Medicaid number or date of birth or a unique identifier (e.g., an individual's medical record number);

b. A detailed description of the ~~item or~~ items being delivered, including the product ~~name or~~ names and ~~brand or~~ brands;

c. The serial ~~number or~~ numbers or the product numbers of the DME ~~or supplies~~, if available;

d. The quantity delivered; and

e. The dated signature of either the individual or his caregiver.

2. If a commercial shipping service is used, the DME provider's records shall reference, in addition to the information required in subdivision 1 of this subsection, the delivery service's package identification ~~number or~~ numbers with a copy of the delivery service's delivery ticket, which may be printed from the online record on the delivery service's website.

a. The delivery service's ticket identification ~~number or~~ numbers shall be recorded on the DME provider's delivery documentation.

b. The service delivery documentation may be substituted for the individual's signature as proof of delivery.

c. In the absence of a delivery service's ticket, the DME provider shall obtain the individual's or his caregiver's dated signature on the DME provider's delivery ticket as proof of delivery.

3. Providers may use a postage-paid delivery invoice from the individual or his caregiver as a form of proof of delivery. The descriptive information concerning the ~~item or~~ items delivered, as described in subdivisions 1 and 2 of this subsection, as well as the required signature and date from either the individual or his caregiver, shall be included on this invoice.

4. DME providers shall make affirmative contact with the individual or his caregiver and document the interaction prior to dispensing repeat orders or refills to ensure that:

a. The item is ~~still~~ needed;

b. The quantity, frequency, and product are ~~still~~ appropriate; and

c. The individual ~~still~~ resides at the address in the provider's records.

5. The DME provider shall contact the individual prior to each delivery. This contact shall not occur any sooner than seven days prior to the delivery or shipping date and shall be documented in the individual's record.

6. DME providers shall not deliver refill orders sooner than five days prior to the end of the usage period.

7. Providers shall not bill for dates of service prior to delivery. The provider shall confirm receipt of the DME ~~or supplies~~ via the shipping service record showing the item was delivered prior to billing. Claims for refill orders shall be the start of the new usage period and shall not overlap with the previous usage period.

8. The purchase prices listed in the Virginia Medicaid Durable Medical Equipment and Supplies Manual, Appendix B, represent the amount DMAS shall pay for newly purchased equipment. Unless otherwise approved by DMAS or its designated agent, documentation on the delivery ticket shall reflect that the purchased equipment is new upon the date of the service billed. Any warranties associated with new equipment shall be effective from the date of the service billed. Since Medicaid is the payer of last resort, the DME provider shall explore coverage

available under the warranty prior to requesting coverage of repairs from DMAS.

9. DME ~~and supplies~~ for home use for an individual being discharged from a hospital or nursing facility may be delivered to the hospital or nursing facility one day prior to the discharge. However, the DME provider's claim date of service shall not begin prior to the date of the individual's discharge from the hospital or nursing facility.

M. Enteral nutrition products. Coverage of enteral nutrition (EN) that does not include a legend drug shall be limited to when the nutritional supplement ~~is the sole source form of nutrition,~~ is administered orally or through a nasogastric or gastrostomy tube~~,~~ and is necessary to treat a medical condition. DMAS shall provide coverage for nutritional supplements for enteral feeding only if the nutritional supplements are not available over the counter. Additionally, DMAS shall cover medical foods that are (i) specific to inherited diseases, metabolic disorders, PKU, etc.; (ii) not generally available in grocery stores, health food stores, or the retail section of a pharmacy; and (iii) not used as food by the general population. Coverage of EN shall not include the provision of routine infant formula or feedings as meal replacement only. Coverage of medical foods shall not extend to regular foods prepared to meet particular dietary restrictions, limitations, or needs, such as meals designed to address the situation of individuals with diabetes or heart disease. A nutritional assessment shall be required for all ~~recipients~~ individuals for whom nutritional supplements are ordered.

1. General requirements and conditions.

a. Enteral nutrition products shall only be provided by enrolled DME providers.

b. DME providers shall adhere to all applicable DMAS policies, laws, and regulations. DME providers shall also comply with all other applicable Virginia laws and regulations requiring licensing, registration, or permitting. Failure to comply with such laws and regulations shall result in denial of coverage for enteral nutrition that is regulated by such licensing agency ~~or agencies~~.

2. Service units and service limitations.

a. DME ~~and supplies~~ shall be furnished pursuant to the Certificate of Medical Necessity ~~(CMN)~~ (DMAS-352).

b. The DME provider shall include documentation related to the nutritional evaluation findings on the CMN and may include supplemental information on any supportive documentation submitted with the CMN.

c. DMAS shall reimburse for medically necessary formulae and medical foods when used under a licensed practitioner's direction to augment dietary limitations or provide primary nutrition to individuals via enteral or oral feeding methods.

d. The CMN shall contain a licensed practitioner's order for the enteral nutrition products that are medically necessary to treat the diagnosed condition and the individual's functional limitation. The justification for enteral nutrition products shall be demonstrated in the written documentation either on the CMN or on the attached supporting documentation. The CMN shall be valid for a maximum period of six months.

e. Regardless of the amount of time that may be left on a six-month approval period, the validity of the CMN shall terminate when the individual's medical need for the prescribed enteral nutrition products ~~either~~ ends, as determined by the licensed practitioner~~, or when the enteral nutrition products are no longer the primary source of nutrition~~.

f. A face-to-face nutritional assessment completed by trained clinicians (e.g., physician, physician assistant, nurse practitioner, registered nurse, or a registered dietitian) shall be completed as required documentation of the need for enteral nutrition products.

~~g. The CMN shall not be changed, altered, or amended after the licensed practitioner has signed it. As indicated by the individual's condition, if changes are necessary in the ordered enteral nutrition products, the DME provider shall obtain a new CMN.~~

~~(1) New CMNs shall be signed and dated by the licensed practitioner within 60 days from the time the ordered enteral nutrition products are furnished by the DME provider.~~

~~(2) The order shall not be backdated to cover prior dispensing of enteral nutrition products. If the order is not signed within 60 days of the service initiation, then the date the order is signed becomes the effective date.~~

~~h.~~ g. Prior authorization of enteral nutrition products shall not be required. The DME provider shall assure that there is a valid CMN (i) completed every six months in accordance with subsection B of this section and (ii) on file for all Medicaid individuals for whom enteral nutrition products are provided.

(1) The DME provider is further responsible for assuring that enteral nutrition products are provided in accordance with DMAS reimbursement criteria in 12VAC30-80-30 A 6.

(2) Upon post payment review, DMAS or its designated contractor may deny reimbursement for any enteral nutrition products that have not been provided and billed in accordance with ~~these regulations~~ this section and DMAS policies.

~~i.~~ h. DMAS shall have the authority to determine that the CMN is valid for less than six months based on medical documentation submitted.

3. Provider responsibilities.

a. The DME provider shall provide the enteral nutrition products as prescribed by the licensed practitioner on the CMN. Physician orders shall not be changed unless the DME provider obtains a new CMN prior to ordering or providing the enteral nutrition products to the individual.

b. The licensed practitioner's order ~~(CMN)~~ on the CMN shall ~~state that the enteral nutrition products are the sole source of nutrition for the individual and~~ specify either a brand name of the enteral nutrition product being ordered or the category of enteral nutrition products that must be provided. If a licensed practitioner orders a specific brand of enteral nutrition product, the DME provider shall supply the brand prescribed. The licensed practitioner order shall include the daily caloric intake and the route of administration for the enteral nutrition product. ~~Additional supporting~~ Supporting documentation may be attached to the CMN, but the entire licensed practitioner's order shall be on the CMN.

c. The CMN shall be signed and dated by the licensed practitioner within 60 days of the CMN begin service date. The order shall not be backdated to cover prior dispensing of enteral nutrition products. If the CMN is not signed and dated by the licensed practitioner within 60 days of the CMN begin service date, the CMN shall ~~not~~ become valid ~~until the~~ on the date of the licensed practitioner's signature.

d. The CMN shall include all of the following elements:

(1) Height of individual (or length for pediatric patients);

(2) Weight of individual. For initial assessments, indicate the individual's weight loss over time;

(3) Tolerance of enteral nutrition product (e.g., is the individual experiencing diarrhea, vomiting, constipation). This element is only required if the individual is already receiving enteral nutrition products;

~~(4) Indication of whether or not the enteral nutrition product is the primary or sole source of nutrition;~~

~~(5)~~ (4) Route of administration; and

~~(6)~~ (5) The daily caloric order and the number of calories per package or can~~; and~~.

~~(7) Extent to which the quantity of the enteral nutrition product is available through WIC, the Special Supplemental Nutrition Program for Women, Infants and Children.~~

~~e. The DME provider shall retain a copy of the CMN and all supporting verifiable documentation on file for DMAS' post-payment review purposes. DME providers shall not create or revise CMNs or supporting documentation for this service after the initiation of the post payment review process. Licensed practitioners shall not complete or sign and date CMNs once the post payment review has begun.~~

~~f.~~ e. Medicaid reimbursement shall be recovered when the enteral nutrition products have not been ordered on the CMN. Supporting documentation is allowed to justify the medical need for enteral nutrition products. Supporting documentation shall not replace the requirement for a properly completed CMN. The dates of the supporting documentation shall coincide with the dates of service on the CMN, and the supporting documentation shall be ~~fully~~ signed and dated by the licensed practitioner.

~~g. To receive reimbursement, the DME provider shall:~~

~~(1) Deliver only the item or items and quantity or quantities ordered by the licensed practitioner and approved by DMAS or the designated prior or service authorization contractor;~~

~~(2) Deliver only the item or items for the periods of service covered by the licensed practitioner's order and approved by DMAS or the designated prior or service authorization contractor;~~

~~(3) Maintain a copy of the licensed practitioner's order and all verifiable supporting documentation for all DME ordered; and~~

~~(4) Document all supplies provided to an individual in accordance with the licensed practitioner's orders. The delivery ticket must document the individual's name and Medicaid number, the date of delivery, the item or items that were delivered, and the quantity delivered.~~

~~h.~~ N. Reimbursement denials.

1. DMAS shall deny payment to the DME provider if any of the following occur:

~~(1)~~ a. Absence of a current, fully completed CMN appropriately signed and dated by the licensed practitioner;

~~(2)~~ b. Documentation does not verify that the item was provided to the individual;

~~(3)~~ c. Lack of medical documentation, signed by the licensed practitioner to justify the ~~enteral nutrition products~~ DME; or

~~(4)~~ d. Item is noncovered or does not meet DMAS criteria for reimbursement.

~~i.~~ 2. If reimbursement is denied by Medicaid, the DME provider shall not bill the Medicaid individual for the service that was provided.

O. Replacement DME following a natural disaster.

1. Medicaid individuals who (i) live in a disaster area, (ii) can prove they were present in the disaster area when the disaster occurred, or (iii) live in areas that have been declared by the Governor as a disaster or emergency area in accordance with § 44-146.16 of the Code of Virginia, and who need to replace DME previously approved by Medicaid that were damaged as a result of the disaster or emergency, may contact a DME provider (either enrolled in fee-for-service Medicaid or a Medicaid health plan) of their choice to obtain a replacement.

a. If the individual's DME provider has gone out of business or is unable to provide replacement DME, the individual may choose another provider who is enrolled as a DME provider with Medicaid or the Medicaid health plan. The original authorization will be canceled or amended and a new authorization will be provided to the new DME provider.

b. The DME provider shall submit a signed statement from the Medicaid individual requesting a change in DME provider in accordance with the declaration by the Governor as a state of emergency due to a natural disaster and giving the Medicaid individual's current place of residence.

c. The individual can contact the state Medicaid office or the Medicaid health plan to get help finding a new DME provider.

2. For Medicaid enrolled providers, the provider shall make a request to the service authorization contractor; however, a new CMN and medical documentation is not required unless the DME is beyond the service limit (e.g., the individual has a wheelchair that is older than five years). The provider shall keep documentation in the individual's record that includes the individual's current place of residence and states that the original DME was lost due to the natural disaster.

VA.R. Doc. No. R17-5024; Filed February 6, 2019, 9:18 a.m.

Fast-Track Regulation

Title of Regulation: **12VAC30-120. Waivered Services (amending 12VAC30-120-360 through 12VAC30-120-430).**

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: April 3, 2019.

Effective Date: April 18, 2019.

Agency Contact: Emily McClellan, Regulatory Manager, Division of Policy and Research, 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 authorizes the Board of Medical Assistance Services to administer and amend the State Plan for Medical Assistance and promulgate regulations. Section 32.1-324 of the Code of Virginia authorizes the Director of DMAS to administer and amend the State Plan for Medical Assistance according to the board's requirements and promulgate regulations. 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 bring Virginia regulations into alignment with current federal rules, Medallion contracts, and current practice. The regulations are essential to protect the health, safety, and welfare of citizens in that the regulatory changes ensure compliance with federal requirements, which ensures continued federal financial participation, and enables continued funding for Medicaid managed care programs.

Rationale for Using Fast-Track Rulemaking Process: This regulatory action is being promulgated as a fast-track rulemaking because it is expected to be noncontroversial. The changes in the regulatory text do not reflect changes in Medicaid programs, but instead update the text to reflect changes that have already been made in Medallion contracts and practice.

Substance: This regulatory action includes changes in the Code of Federal Regulations related to the Medicaid Managed Care Final Rule, as well as changes in the Medallion contract and the appeals process.

Issues: The primary advantages to the Commonwealth and the public of these regulatory changes are that they update existing regulations to reflect current practice to allow for continued federal financial participation.

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 update the regulation to reflect changes in federal rules as well as changes in the recent provider contract as they pertain to the Medallion program.

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

Estimated Economic Impact. Medallion is a managed care program that focuses on coverage of low-income children and families. The proposed changes would amend the Waivered

Services regulation to incorporate changes that have been made in the federal Medicaid Managed Care Final Rule in the Code of Federal Regulations.[1] The regulation would also be updated to reflect changes in the most recent Medallion contract that were made following the federal rule changes. The main proposed changes pertain to the managed care appeals process and coverage of community mental health services, early intervention services and long-term care services through the managed care plans.

All of the proposed changes have already been implemented. Thus, no significant economic effect is expected upon promulgation of this regulation. The proposed changes are beneficial, however, in that outdated regulatory language would be updated with new language that reflects the current rules already in place.

Businesses and Entities Affected. There are six managed care organizations participating in the current Medallion program.

Localities Particularly Affected. No locality should be affected any more than others.

Projected Impact on Employment. No impact on employment is expected upon the proposed amendments taking affect.

Effects on the Use and Value of Private Property. No effects on the use and value of private property is expected upon the proposed amendments taking affect.

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. The proposed amendments do not affect 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.

[1]https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf

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 update the regulation to reflect changes in (i) federal regulation related to the Medicaid Managed Care Final Rule, (ii) the current Medallion contract, and (iii) the managed care appeals process.

Part VI
Medallion Mandatory Managed Care

12VAC30-120-360. Definitions.

The following words and terms when used in this part shall have the following meanings unless the context clearly indicates otherwise. All other words and terms used in this part shall comply with the definitions in the contract and those identified 42 CFR 438.2:

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

"Adverse benefit determination" means, consistent with 42 CFR 438.400, (i) the denial or limited authorization of a requested service; (ii) the failure to take action or timely take action on a request for service; (iii) the reduction, suspension, or termination of a previously authorized service; (iv) the denial in whole or in part of a payment for a covered service; (v) the failure to provide services within the timeframes required by the state, or for a resident of a rural exception area with only one MCO, the denial of a member's request to exercise his right under 42 CFR 438.52(b)(2)(ii) to obtain services outside of the network; (vi) the denial of a member's request to dispute a financial liability; or (vii) the failure of an MCO to act within the timeframes provided in 42 CFR 438.408(b).

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

"Appeal" when applicable to a member means a request to DMAS to review an MCO's internal appeal decision to uphold the contractor's adverse benefit determination. For members, an appeal may only be requested after exhaustion of the MCO's one step internal appeal process. Member appeals to DMAS will be conducted in accordance with regulations at 42 CFR 431 Subpart E and 12VAC30-110-10 through 12VAC30-110-370.

"Appeal" when applicable to an appeal by a provider means a request to DMAS to review an MCO's reconsideration

decision. For providers, an appeal may only be requested after exhaustion of the MCO's reconsideration process. Provider appeals to DMAS will be conducted in accordance with the requirements set forth in § 2.2-4000 et seq. of the Code of Virginia and 12VAC30-20-500 et seq.

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

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

"Day" means calendar day unless otherwise stated.

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

"DMAS" means the Department of Medical Assistance Services.

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

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

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

~~1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,~~

~~2. Serious impairment to bodily functions, or~~

~~3. Serious dysfunction of any bodily organ or part.~~

"Emergency services" means ~~covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services and that are needed to evaluate or stabilize an emergency medical condition.~~ those health care services that are rendered by participating or nonparticipating providers after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (i) placing the client's health in serious jeopardy; (ii) with respect to a pregnant woman, placing the health of the woman or her unborn child in serious jeopardy; (iii) serious impairment to bodily functions; or (iv) serious dysfunction of any bodily organ or part.

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

"Exclude" means the removal of a member from the Medallion mandatory managed care program on a temporary or permanent basis.

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

"Grievance" means, in accordance with 42 CFR 438.400, an expression of dissatisfaction about any matter other than an ~~"action" is defined in this section~~ "adverse benefit determination." Possible subjects for grievances include the quality of care or services provided; aspects of interpersonal relationships, such as rudeness of a provider or employee; or failure to respect the member's rights.

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

"Individual" ~~or "individuals"~~ means a person ~~or persons~~ who ~~are~~ is eligible for Medicaid~~,~~ who ~~are~~ is not yet undergoing enrollment for mandatory managed care~~,~~ and who ~~are~~ is not enrolled in a mandatory managed care organization.

"Internal appeal" means a request to the MCO by a member or by a member's authorized representative or provider acting on behalf of the member and with the member's written consent for review of a contractor's adverse benefit determination, as defined in 42 CFR 438.400. The internal appeal is the only level of appeal with the MCO and must be exhausted by a member or deemed exhausted according to 42 CFR 438.408(c)(3) before the member may initiate a state fair hearing with DMAS.

"Managed care organization" or "MCO" means an ~~entity that meets the participation and solvency criteria defined in 42 CFR Part 438 and has an executed contractual agreement with DMAS to provide services covered under the mandatory managed care program. Covered services for mandatory managed care program individuals shall be as accessible (in terms of timeliness, amount, duration, and scope) as compared to other Medicaid individuals served within the geographic area.~~ organization that offers managed care health insurance plans (MCHIP), as defined by § 38.2-5800 of the Code of Virginia. Any health maintenance organization as defined in § 38.2-4300 of the Code of Virginia or health carrier that offers preferred provider contracts or policies as defined in § 38.2-3407 of the Code of Virginia or preferred

provider subscription contracts as defined in § 38.2-4209 of the Code of Virginia shall be deemed to be offering one or more MCHIPs. For the purposes of this definition, the prohibition of balance billing by a provider shall not be deemed a benefit payment differential incentive for covered persons to use providers who are directly or indirectly managed by, owned by, under contract with, or employed by the health carrier. A single managed care health insurance plan may encompass multiple products and multiple types of benefit payment differentials; however, a single managed care health insurance plan shall encompass only one provider network or set of provider networks.

Additionally, and in accordance with 42 CFR 438.2, "managed care organization" or "MCO" means an entity that has qualified to provide the services covered in the Medallion program to qualifying Medallion members as accessible in terms of timeliness, amount, duration, and scope as those services are to other Medicaid members within the area served, and that meets the solvency standards of 42 CFR 438.116.

"Mandatory managed care program" means the same as set forth in 42 CFR 438.54(b) and (d).

"Member" ~~or "members"~~ means ~~people who have current Medicaid eligibility who are also enrolled in mandatory managed care~~ a person eligible for Medicaid or Family Access to Medical Insurance Security who has been assigned to a Medicaid MCO.

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

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

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

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

"Reconsideration" means a provider's request to the MCO for review of an adverse benefit determination. The MCO's reconsideration decision is a prerequisite to a provider's filing of an appeal, as provided for in 12VAC30-20-500 through 12VAC30-20-560, to DMAS Appeals Division.

"Rural exception" means a rural area designated in the § 1915(b) managed care waiver, pursuant to § 1932(a)(3)(B) of the Social Security Act and 42 CFR 438.52(b) and recognized by the Centers for Medicare and Medicaid Services, wherein qualifying mandatory managed care members are mandated to enroll in the one available contracted MCO.

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

12VAC30-120-370. ~~Mandatory~~ Medallion mandatory managed care members.

A. DMAS shall determine enrollment in Medallion mandatory managed care.

1. Medicaid eligible persons not meeting the exclusion criteria set out in subsection B of this section shall participate in the Medallion mandatory managed care program. Enrollment in Medallion mandatory managed care shall not be a guarantee of continuing eligibility for services and benefits under the Virginia Medical Assistance Services Program.

~~1.~~ 2. DMAS reserves the right to exclude from participation in the Medallion mandatory managed care program any member who has been consistently noncompliant with the policies and procedures of managed care or who is threatening to providers, MCOs, or DMAS. There must be sufficient documentation from various providers, the MCO, and DMAS of these noncompliance issues and any attempts at resolution. Members excluded from Medallion mandatory managed care through this provision may appeal the decision to DMAS.

~~2. Qualifying individuals enrolled in the Elderly or Disabled with Consumer Direction (EDCD) Waiver pursuant to Part IX (12VAC30-120-900 et seq.) of this chapter who do not meet any exclusions in subsection B of this section shall be required to enroll in managed care and shall receive all acute care services through the mandatory managed care delivery system. For these individuals, services provided under 12VAC30-120-380 A 2 shall continue to be provided through the DMAS fee-for-service system.~~

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

1. Individuals who are inpatients in state mental hospitals;

2. Individuals who are approved by DMAS as inpatients in long-stay hospitals, nursing facilities, or intermediate care facilities for individuals with intellectual disabilities;

3. Individuals who are placed on spend-down, which is the process of reducing countable income by deducting

incurred medical expenses for medically needy individuals, as determined in the State Plan for Medical Assistance;

4. Individuals who are participating in the family planning waiver~~, or in federal waiver programs for home based and community based Medicaid coverage prior to managed care enrollment (except eligible EDCD members)~~;

5. ~~Individuals under age~~ Prior to April 1, 2019, individuals younger than 21 years of age who are approved for DMAS residential facility Level C programs as defined in 12VAC30-130-860;

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

~~7.~~ 6. Individuals, other than students, who permanently live outside their area of residence, which is the member's address in the Medicaid eligibility file, for greater than 60 consecutive days except those individuals placed there for medically necessary services funded by the MCO;

~~8.~~ 7. Individuals who receive hospice services in accordance with DMAS criteria;

~~9.~~ 8. Individuals with ~~other comprehensive group or individual health insurance coverage, including Medicare, insurance provided to military dependents, and any other~~ insurance purchased through the Health Insurance Premium Payment Program (HIPP);

~~10.~~ 9. Individuals requesting exclusion who are inpatients in hospitals, other than those listed in subdivisions 1 and 2 of this subsection, at the scheduled time of MCO enrollment or who are scheduled for inpatient hospital stay or surgery within 30 calendar days of the MCO enrollment effective date. The exclusion shall remain effective until the first day of the month following discharge. This exclusion reason shall not apply to members admitted to the hospital while already enrolled in a department-contracted MCO;

~~11.~~ 10. Individuals who request exclusion during assignment to an MCO or within a time set by DMAS from the effective date of their MCO enrollment, who have been diagnosed with a terminal condition and who have a life expectancy of six months or less. The individual's physician must certify the life expectancy;

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

~~13.~~ 11. Individuals who have an eligibility period that is less than three months;

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

~~15.~~ 12. Individuals who have an eligibility period that is only retroactive; and

~~16.~~ 13. Children enrolled in the Virginia Birth-Related Neurological Injury Compensation Program established pursuant to Chapter 50 (§ 38.2-5000 et seq.) of Title 38.2 of the Code of Virginia.

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

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

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

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

E. ~~Mandatory~~ Medallion mandatory managed care plans shall be offered to individuals, and individuals shall be enrolled in those plans~~, exclusively through an~~. DMAS has sole responsibility for determining enrollment in the contractor's plan. DMAS utilizes an independent enrollment broker under contract to DMAS to assist members with making plan choices after initial preassignment and during open enrollment. An enrollment broker is an independent contractor that enrolls individuals in the contractor's plan and is responsible for the operation and documentation of a toll-free individual service helpline.

F. Members shall be enrolled as follows:

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

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

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

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

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

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

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

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

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

1. Individuals are assigned through a system algorithm based upon the member's history with a contracted MCO.

2. Individuals not assigned pursuant to subdivision 1 of this subsection shall be assigned to the MCO of another family member~~,~~ if applicable.

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

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

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

6. DMAS shall have the discretion to ~~utilize~~ use an alternate strategy for enrollment or transition of enrollment from the method described in this section for expansions, retractions, or changes to member populations, geographical areas, procurements, or any or all of these; such alternate strategy shall comply with federal waiver requirements. "Retractions" means the departure of an enrolled managed care organization from any one or more localities as provided in this section.

H. Following ~~their~~ the member's initial enrollment into an MCO, ~~members~~ the member shall be restricted to the MCO

until the next open enrollment period, unless appropriately disenrolled or excluded by the department ~~(as,~~ as defined in 12VAC30-120-360~~)~~.

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

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

I. The department shall conduct an annual open enrollment for all Medallion mandatory managed care members with the exception of those members who live in a designated rural exception area. The open enrollment period shall be the 60 ~~calendar~~ days before the end of the enrollment period. Prior to the open enrollment period, DMAS will inform the member of the opportunity to remain with the current MCO or change to another MCO, without cause, for the following year. Enrollment selections will be effective on the first day of the next month following the open enrollment period. Members who do not make a choice during the open enrollment period will remain with their current MCO selection.

J. Disenrollment for cause may be requested at any time~~.~~ and the disenrollment reasons shall be in accordance with 42 CFR 438.56 (d)(2)(v).

1. ~~After the first 90 days of enrollment in an MCO, members may request disenrollment from DMAS based on cause.~~ The request may be made orally or in writing to DMAS and shall cite the reason or reasons why the member wishes to disenroll. Cause for disenrollment shall ~~include~~ be in accordance with 42 CFR 438.56(d)(2), which includes the following reasons:

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

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

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

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

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

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

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

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

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

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

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

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

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

K. In accordance with 42 CFR 438.3(q)(5) and 42 CFR 438.56(c)(2), a member has the right to disenroll from the contractor's plan without cause at the following times:

1. During the 90 days following the date of the member's initial enrollment into the MCO or during the 90 days

following the date DMAS sends the member notice of that enrollment, whichever is later.

2. At least once every 12 months thereafter.

3. Upon automatic reenrollment under subsection G of this section if the temporary loss of Medicaid eligibility has caused the beneficiary to miss the annual disenrollment opportunity.

4. When DMAS imposes the intermediate sanction specified in 42 CFR 438.702(a)(4).

12VAC30-120-380. Medallion MCO responsibilities.

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

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

2. Services that shall be provided outside the MCO network shall include~~, but are not limited to,~~ those services identified and defined by the contract between DMAS and the MCO. Services reimbursed by DMAS include dental and orthodontic services for children ~~up to age~~ younger than 21~~; for all others~~ years of age, dental services for others ~~(~~as described in 12VAC30-50-190~~)~~, and school health services~~, community mental health services (12VAC30-50-130 and 12VAC30-50-226); early intervention services provided pursuant to Part C of the Individuals with Disabilities Education Act (IDEA) of 2004 (as defined in 12VAC30-50-131 and 12VAC30-50-415); and long-term care services provided under the § 1915(c) home-based and community-based waivers including related transportation to such authorized waiver services~~.

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

B. ~~EPSDT~~ Early and periodic screening, diagnostic, and treatment (EPSDT) services shall be covered by the MCO and defined by the contract between DMAS and the MCO. The MCO shall have the authority to determine the provider of service for EPSDT screenings.

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

D. Documentation requirements.

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

2. Each MCO shall ~~have written policies regarding member rights and shall comply with any applicable federal and state laws that pertain to member rights and shall ensure that its staff and affiliated providers take those rights into account when furnishing services to members in accordance with 42 CFR 438.100.~~ comply with the member rights and protections stipulated in the contract and as identified in 42 CFR 438 Subpart C.

E. The MCO shall comply with the contract and 42 CFR 438 Subparts E and H to ensure that the health care provided to its members meets all applicable federal and state mandates, community standards for quality, and standards developed pursuant to the DMAS managed care quality program.

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

G. The MCOs shall meet the standards specified in 42 CFR 438, Subpart D by DMAS for sufficiency of provider networks as specified in the contract between the Commonwealth and the MCO.

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

I. In accordance with 42 CFR 447.50 through 42 CFR ~~447.60~~ 447.90, MCOs shall not impose any cost sharing obligations on members except as set forth in 12VAC30-20-150 and 12VAC30-20-160.

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

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

12VAC30-120-390. Payment rate for MCOs.

The payment rate to MCOs that participate in the Medallion mandatory managed care program shall be set by negotiated contracts and in accordance with 42 CFR ~~438.6~~ 438.4 through 42 CFR 438.8 and other pertinent federal regulations.

12VAC30-120-395. ~~Payment~~ Preauthorized, emergency, and post-stabilization services and payment rate for ~~preauthorized or emergency~~ care provided by out-of-network providers.

The MCOs shall pay for preauthorized ~~or,~~ emergency, and post-stabilization services ~~when provided outside the MCO network~~ to members in compliance with the contract and 42 CFR 438.114. Preauthorized ~~or,~~ emergency, and post-stabilization services provided to a managed care member by a provider or facility not participating in the MCO's network will be reimbursed according to the current Medicaid fee schedule. This reimbursement shall be considered payment in full to the provider or facility of emergency services.

12VAC30-120-400. Quality control and utilization review.

A. DMAS shall rigorously monitor the quality of care provided by the MCOs. DMAS ~~may contract with one or more external quality review organizations to perform focused studies on the quality of care provided by the MCOs. The external organizations may utilize data or other tools to ensure contract compliance and quality improvement activities. Specifically~~ and the MCOs shall comply with (i) the contract; (ii) 42 CFR 438 Subpart E, entitled Quality Measurement and Improvement: External Quality Review; and (iii) the MCO standards identified in 42 CFR 438 Subpart D, entitled MCO, PIHP, and PAHP Standards. DMAS shall monitor the MCOs to determine ~~if the MCO:~~ their compliance with the contract, 42 CFR Subpart A, and all other relevant sections of 42 CFR Part 438 (Managed Care) as follows:

1. ~~Fails~~ If the MCO fails substantially to provide the medically necessary items and services required under law or under the contract to be provided to an enrolled recipient and the failure has adversely affected ~~(~~or has substantial likelihood of adversely affecting~~)~~ the individual.

2. ~~Engages~~ If the MCO engages in any practice that discriminates against individuals on the basis of their health status or requirements for health care services, including expulsion or refusal to reenroll an individual, or any practice that could reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by § 1903(m) of the Social Security Act (42 USC § 1396b(m))~~)~~ by eligible individuals whose medical conditions or histories indicate a need for substantial future medical services.

3. ~~Misrepresents~~ If the MCO misrepresents or falsifies information that it furnishes, under § 1903(m) of the Social Security Act (42 USC § 1396b(m)) to CMS, DMAS, an individual, or any other entity.

4. ~~Fails~~ If the MCO fails to comply with the requirements of 42 CFR 417.479(d) through 42 CFR 417.479(g) relating to physician incentive plans~~,~~ or fails to submit to DMAS its physician incentive plans as required or requested in 42 CFR 434.70.

5. ~~Imposes~~ If the MCO imposes on members premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.

B. DMAS shall ensure that data on performance and patient results are collected.

C. DMAS shall ensure that quality outcomes information is provided to MCOs. DMAS shall ensure that changes ~~which~~ that are determined to be needed as a result of quality control or utilization review are made.

12VAC30-120-410. Sanctions.

A. If DMAS determines that an MCO is not in compliance with applicable state or federal laws~~,~~ or regulations (including ~~but not limited to~~ the requirements of or pursuant to ~~12VAC30-120-380 E~~ § 1932(e)(1) of the Social Security Act (the Act), 12VAC30-120-380, or 42 CFR 438~~,~~ Subpart I)~~,~~ or the MCO contract, DMAS may impose sanctions on the MCO pursuant to § 1932(e) of the Act and this section. The sanctions may include~~, but are not limited to~~:

1. Limiting enrollments in the MCO by freezing voluntary member enrollments;

2. Freezing DMAS assignment of members to the MCO;

3. Limiting MCO enrollment to specific areas;

4. Denying, withholding, or retracting payments to the MCO;

5. Terminating the MCO's contract as provided in § 1932(e)(4) of the Act;

~~6. Intermediate sanctions including, but not limited to, the maximum civil money penalties specified in 42 CFR Part 438, Subpart I, for the violations set forth therein, or in accordance therewith; and~~

~~7.~~ 6. Civil monetary penalties as specified in 42 CFR 438.704; and

7. Appointment of temporary management for an MCO as provided in 42 CFR 438.706.

B. In the case of an MCO that has repeatedly failed to meet the requirements of §§ 1903(m) and ~~1932~~ 1932(e) of the Social Security Act, DMAS shall, regardless of what other sanctions are imposed, impose the following sanctions:

1. Appoint a temporary manager to:

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

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

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

C. Prior to terminating a contract as permitted under ~~subdivision A 5 of this section~~, § 1932(e)(4) of the Act, DMAS shall provide the MCO with a hearing. DMAS shall not provide an MCO with a ~~pretermination~~ predetermination hearing before the appointment of a temporary manager under subdivision B 1 of this section.

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

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

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

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

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

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

A. The MCOs shall~~, whenever a member's request for covered services is reduced, denied or terminated, or payment for services is denied, provide a written notice in accordance with the notice provisions specified in 42 CFR 438.404 and 42 CFR 438.210(c), as defined by~~ comply with (i) the Grievance and Appeal System as identified in 42 CFR 438 Subpart F, (ii) the Enrollee Rights and Protections requirements in 42 CFR 438 Subpart C, (iii) the Medallion contract between DMAS and the MCO, and (iv) any other applicable state or federal statutory or regulatory requirements.

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

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

1. The member, provider, or representative acting on behalf of the member with the member's written consent may file an oral or written grievance or internal appeal with the MCO. The MCO must accept grievances ~~or appeals~~ filed at any time. Internal appeal requests must be submitted within ~~30~~ 60 days from the date of the notice of adverse ~~action~~ benefit determination. Oral requests for internal appeals must be followed up in writing ~~within 10 business days~~ by the member, provider, or the representative acting on behalf of the member with the member's consent, unless the request is for an expedited internal appeal. ~~The member may also file a written request for a standard or expedited appeal with the DMAS Appeals Division within 30 days of the member's receipt of the notice of adverse action, in accordance with 42 CFR 431, Subpart E; 42 CFR Part 438, Subpart F; and 12VAC30-110-10 through 12VAC30-110-370.~~

2. The member must exhaust the MCO's internal appeals process before appealing to the DMAS Appeals Division. The member may also file a written request for a standard or expedited internal appeal of the MCO's adverse benefit determination with the DMAS Appeals Division within 120 days of the member's receipt of the MCO's internal appeal decision, in accordance with 42 CFR 431 Subpart E; 42 CFR Part 438 Subpart F; and 12VAC30-110-10 through 12VAC30-110-370.

3. As specified in 12VAC30-110-100, pending the resolution of a grievance, internal appeal, or appeal filed by a member or his representative (including a provider acting on behalf of the member) prior to the effective date of the adverse benefit determination, coverage shall not be terminated or reduced for the member for any reason ~~which~~ that is the subject of the grievance or appeal.

~~3.~~ 4. The MCO shall ensure that ~~the employees or agents who make decisions on MCO grievances and appeals were not involved in any previous level of review or decision making, and~~ neither the individuals nor agents, nor a subordinate of any such individual, who makes decisions on grievances and internal appeals were involved in any previous level of review or decision making. Additionally, where the reason for the grievance or internal appeal involves clinical issues~~,~~ or relates to a denial ~~or~~ of a request for an expedited appeal, or where the appeal is based on a lack of medical necessity, the MCO shall ensure that the decision makers are health care professionals with the appropriate clinical expertise in treating the member's condition or disease.

5. The MCO shall provide the member and any representative a reasonable opportunity in person and in writing to present evidence and testimony and to make legal and factual arguments in accordance with 42 CFR 438.406(b)(4). The MCO shall inform the member of the limited time available for this sufficiently in advance of the resolution timeframe for appeals in accordance with 42 CFR 438.406(b)(4).

6. The MCO shall provide the member and any representative the member's case file, including medical records, and any new or additional evidence considered, relied upon, or generated by the MCO in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals in accordance with 42 CFR 438.406(b)(5).

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

E. The MCO shall maintain a recordkeeping, reporting, and tracking system for complaints, grievances, and appeals that ~~includes~~ complies with the Medallion contract between DMAS and the MCO. The system shall include a copy of the original complaint, grievance, or internal appeal; the decision; ~~and~~ the nature of the decision; and data on the number of internal appeals filed, the average time to resolve internal appeals, and the total number of internal appeals open as of the reporting date. This system shall distinguish Medicaid from commercial members~~,~~ if the MCO does not have a separate system for Medicaid members.

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

1. ~~Medical necessity, specialist referral or other service delivery issues~~ An adverse benefit determination may be resolved through a system of grievances and appeals, first within the MCO ~~or~~ and then through the DMAS client appeals process;

2. Members have the right to request an expedited internal appeal ~~directly to DMAS~~;

3. Members shall exhaust their internal appeals with the MCO before being given the right to appeal to DMAS; and

4. The MCO shall promptly provide grievance or appeal forms, reasonable assistance, and written procedures to members who wish to register written grievances or appeals, including auxiliary aids and services upon request such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

G. The MCO shall issue ~~grievance/appeal~~ grievance or internal appeal decisions as defined by 42 CFR 438.408 and the contract between DMAS and the MCO. Oral grievance decisions are not required to be in writing.

H. The MCO shall issue standard internal appeal decisions within 30 days from the date of initial receipt of the internal appeal in accordance with 42 CFR 438.408 and as defined by the Medallion contract between DMAS and the MCO. This timeframe may be extended by up to 14 days under the requirements of 42 CFR 438.408. The internal appeal decision shall be in writing and shall include~~, but shall not be limited to,~~ the following:

1. The decision reached, the results, and the date of the decision reached by the MCO;

2. The reasons for the decision;

3. The policies or procedures that provide the basis for the decision;

4. ~~A clear explanation of further appeal rights and a timeframe for filing an appeal; and~~ For internal appeals not resolved wholly in favor of the member:

a. A clear explanation of further appeal rights and a timeframe for filing an internal appeal; and

b. The right to continue to receive benefits in accordance with 42 CFR 438.420 pending a hearing and how to request continuation of benefits.

The member may be held liable for the cost of those benefits if the hearing decision upholds the contractor's adverse benefit determination.

~~5. For appeals that involve the termination, suspension, or reduction of a previously authorized course of treatment, the right to continue to receive benefits in accordance with 42 CFR 438.420 pending a hearing, and how to request continuation of benefits.~~

I. An expedited appeal decision shall be issued as expeditiously as the member's condition requires and within ~~three business days~~ 72 hours from receipt of the internal appeal request in cases of medical emergencies in which delay could result in death or serious injury to a member. Extensions to these timeframes shall be allowed in accordance with 42 CFR 438.408 and as defined by the Medallion contract between DMAS and the MCO. Written confirmation of the decision shall promptly follow the verbal notice of the expedited decision.

J. If the MCO fails to adhere to the internal appeals notice and timing requirements of this section, the member is deemed to have exhausted the MCO's internal appeals process and may file an internal appeal with DMAS.

K. Any adverse benefit determination upheld in whole or in part by the internal appeal decision issued by the MCO may be appealed by the member to DMAS in accordance with the ~~department's Client Appeals~~ DMAS appeals regulations at 12VAC30-110-10 through 12VAC30-110-370. DMAS shall conduct an evidentiary hearing in accordance with the Client Appeals regulations at 12VAC30-110-10 through 12VAC30-110-370 and shall not base any appealed decision on the record established by any internal appeal decision of the MCO. The MCO shall comply with the DMAS appeal decision. The DMAS decision in these matters shall be final and shall not be subject to appeal by the MCO.

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

12VAC30-120-430 ~~to 12VAC30-120-440~~. ~~[Reserved]~~ Provider grievances, reconsiderations, and appeals.

A. The MCOs shall comply with the requirements of the Administrative Process Act (§§ 2.2-4000 et seq. of the Code of Virginia), the provider appeals regulations at 12VAC30-20-500 through 12VAC30-20-560, the Medallion contract between DMAS and the MCO, and any other applicable state or federal statutory or regulatory requirements.

B. The MCOs shall have a grievance system established to respond to grievances made by network providers. Network provider grievances are not appealable to the DMAS Appeals Division.

C. MCOs shall, at the initiation of new network provider contracts, provide to every network provider the information described in this section concerning grievance, reconsideration, and appeal rights and procedures.

D. Disputes between the MCO and the network provider concerning any aspect of reimbursement shall be resolved through a verbal or written grievance or reconsideration process operated by the MCO or through the DMAS appeals process. A network provider or representative that is authorized by the network provider may act on behalf of a network provider in the MCO grievance or reconsideration or the DMAS appeals process.

E. Disputes arising solely from the MCO's denial or termination of a provider's enrollment in the MCO's network are not appealable to the DMAS Appeals Division.

F. If a network provider has rendered services to a member and has been denied authorization or reimbursement for the services or has received reduced authorization or reimbursement, that provider may request a reconsideration of the denied or reduced authorization or reimbursement. Before appealing to DMAS, network providers must first exhaust all MCO reconsideration processes. The MCO's final denial letter must include a statement that the provider has exhausted its reconsideration rights with the MCO and that the next level of appeal is with DMAS. The final denial letter must include the appeal rights to DMAS in accordance with the provider appeals regulations at 12VAC30-20-500 through 12VAC30-20-560.

G. All network provider appeals to DMAS must be submitted to the DMAS Appeals Division in writing and within 30 days of the MCO's last date of denial.

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

I. The MCO shall comply with the DMAS appeal decision. A DMAS appeal decision is not appealable by the MCO.

J. The MCO shall maintain a recordkeeping, reporting, and tracking system for complaints, grievances, and reconsiderations that complies with the Medallion contract between DMAS and the MCO. The system shall include a copy of the original complaint, grievance, or reconsideration; the decision; the nature of the decision; and data on the number of reconsiderations filed, the average time to resolve reconsiderations, and the total number of reconsiderations open as of the reporting date.

VA.R. Doc. No. R19-5010; Filed February 5, 2019, 3:55 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: **13VAC10-40. Rules and Regulations for Single Family Mortgage Loans to Persons and Families of Low and Moderate Income (amending 13VAC10-40-10 through 13VAC10-40-190, 13VAC10-40-210, 13VAC10-40-220, 13VAC10-40-230; adding 13VAC10-40-15, 13VAC10-40-240 through 13VAC10-40-280; repealing 13VAC10-40-200).**

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

Effective Date: March 4, 2019.

Agency Contact: Jeff Quann, Senior Counsel, Virginia Housing Development Authority, 601 South Belvidere Street, Richmond, VA 23220, telephone (804) 343-5603 or email jeffrey.quann@vhda.com.

Summary:

The amendments align the regulations with current authority loan programs, policies, and financing sources and incorporate new authority loan programs that have been created since the regulations were last updated in 2009.

Part I
General

13VAC10-40-10. General.

~~The following rules and regulations will be applicable~~ This chapter applies to mortgage loans ~~which~~ that are made or financed or are proposed to be made or financed by the authority to persons and families of low and moderate income for the acquisition (and, where applicable, rehabilitation), construction, refinancing, ownership, and occupancy of single family housing units.

In order to be considered eligible for a mortgage loan ~~hereunder~~ under the provisions of this chapter, the applicant ~~or applicants~~ must have a "gross income" (as determined in accordance with this chapter and the authority's ~~rules and regulations) which~~ origination guide) that does not exceed the applicable income limitation set forth in Part II (13VAC10-40-30 et seq.) ~~hereof~~ of this chapter. Furthermore, the sales price of any single family unit to be financed hereunder must not exceed the applicable sales price limit set forth in Part II ~~(13VAC10-40-30 et seq.) hereof~~. The term "sales price," with respect to a mortgage loan for the combined acquisition and rehabilitation of a single family dwelling unit, shall include the cost of acquisition, plus the cost of rehabilitation and debt service for such period of rehabilitation, not to exceed three months, as the executive director shall determine that such dwelling unit will not be available for occupancy. In addition, each mortgage loan issued a mortgage credit certificate must satisfy all requirements of federal law applicable to ~~loans financed with the proceeds of tax-exempt bonds~~ mortgage credit certificates as set forth in ~~Part II (13VAC10-40-30 et seq.) hereof~~ 13VAC10-190.

Mortgage loans may be made or financed pursuant to ~~these rules and regulations~~ this chapter only if and to the extent that the authority has made or expects to make funds available ~~therefor~~ for such loans. ~~Notwithstanding anything to the contrary herein, the~~ The executive director is authorized with respect to any mortgage loan ~~hereunder~~ made or financed under the provisions of this chapter to waive or modify any provisions of ~~these rules and regulations~~ this chapter where deemed appropriate by him for good cause, to the extent not inconsistent with the Virginia Housing Development Authority Act (§ 36-55.24 et seq. of the Code of Virginia).

All reviews, analyses, evaluations, inspections, determinations, and other actions by the authority pursuant to the provisions of ~~these rules and regulations~~ this chapter shall be made for the sole and exclusive benefit and protection of the authority and shall not be construed to waive or modify any of the rights, benefits, privileges, duties, liabilities, or responsibilities of the authority or the mortgagor under the agreements and documents executed in connection with the mortgage loan.

The rules and regulations set forth ~~herein~~ in this chapter are intended to provide a general description of the authority's processing requirements and are not intended to include all actions involved or required in the originating and administration of mortgage loans under the authority's single family housing program. These rules and regulations ~~are subject to change at any time by the authority and~~ may be supplemented by the authority's origination guide and other policies~~,~~ and rules ~~and regulations~~ adopted by the authority from time to time, to the extent such are not inconsistent with the provisions of this chapter.

13VAC10-40-15. Definitions.

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

"Act" means the Virginia Housing Development Authority Act (§ 36-55.24 et seq. of the Code of Virginia).

"Applicant" means a person who has applied for an authority mortgage loan.

"Authority" means the Virginia Housing Development Authority.

"Borrower" means a person who has obtained an authority mortgage loan.

"Delegated lender" means an originating lender that has received approval from the authority to act in a delegated capacity to approve authority mortgage loans without prior review by the authority.

"Fannie Mae" means the Federal National Mortgage Association.

"Fannie Mae loan" means a mortgage loan made pursuant to the requirements of Fannie Mae.

"FHA" means the U.S. Federal Housing Administration.

"FHA loan" means a mortgage loan insured by FHA.

"First mortgage loan" means a mortgage loan that is in a first lien position.

"Freddie Mac" means the Federal Home Loan Mortgage Corporation.

"Freddie Mac loan" means a mortgage loan made pursuant to the requirements of Freddie Mac.

"Gross income" means the combined annualized gross income of all borrowers and nonborrower occupants taking title to a dwelling unit from whatever source derived and before taxes or withholdings.

"Median family income" has the meaning set forth in § 143(f)(4) of the Internal Revenue Code of 1986.

"Nondelegated lender" means an originating lender that has not received approval from the authority to act in a delegated capacity, such that authority mortgage loans must be submitted to the authority for approval.

"Origination guide" means [~~that~~ the] authority document prepared and revised from time to time, setting forth the accounting and other procedures to be followed by all originating lenders responsible for the origination, closing, and selling of mortgage loans under the applicable purchase agreements.

"Originating agents" means mortgage brokers, financial institutions, and other private firms and individuals and governmental entities approved by the authority for the purpose of receiving applications for mortgage loans.

"Originating lenders" means commercial banks, savings and loan associations, credit unions, private mortgage bankers, redevelopment and housing authorities, and agencies of local government approved by the authority to make mortgage loans pursuant to authority loan programs.

"Present ownership interest" means an ownership interest in a principal residence including:

1. A fee simple interest;

2. A joint tenancy, a tenancy in common, or a tenancy by the entirety;

3. The interest of a tenant shareholder in a cooperative;

4. A life estate;

5. A land contract, under which possession and the benefits and burdens of ownership are transferred although legal title is not transferred until some later time; and

6. An interest held in trust for the eligible borrower (whether or not created by the eligible borrower) that would constitute a present ownership interest if held directly by the eligible borrower.

Interests that do not include a present ownership interest include:

1. A remainder interest;

2. An ordinary lease with or without an option to purchase;

3. A mere expectancy to inherit an interest in a principal residence;

4. The interest that a purchaser of a [~~resident~~ residence] acquires on the execution of an accepted offer to purchase real estate; and

5. An interest in other than a principal residence during the previous three years.

"Purchase agreement" means an agreement entered into between an originating lender and the authority containing such terms and conditions as the executive director shall require with respect to the origination and selling of mortgage loans to the authority.

"Rural Development loan" means the U.S. Department of Agriculture Rural Development mission area, and one of its agencies, the Rural Housing Service.

"Targeted areas" means those areas which are a qualified census tract or an area of chronic economic distress. A qualified census tract is a census tract in the Commonwealth in which 70% or more of the families have an income of 80% or less of the statewide median family income based on the most recent "safe harbor" statistics published by the U.S. Treasury. An area of chronic economic distress is an area designated as such by the Commonwealth and approved by the Secretaries of Housing and Urban Development and the Treasury under criteria specified in the tax code. Originating lenders will be informed by the authority as to the location of areas so designated.

"Tax code" means the Internal Revenue Code of 1986, as amended (26 USC § 1 et seq.).

"VA" means the U.S. Department of Veterans Affairs.

"VA loan" means a mortgage loan that is guaranteed by VA.

13VAC10-40-20. Origination and servicing of mortgage loans.

A. The originating of mortgage loans and the processing of applications for the making or financing thereof in accordance ~~herewith~~ with this chapter shall, except as noted in subsection ~~G~~ L of this section, be performed through ~~commercial banks, savings and loan associations, private mortgage bankers, redevelopment and housing authorities, and agencies of local government approved as~~ originating ~~agents ("originating agents") of the authority~~ lenders. The servicing of mortgage loans shall~~, except as noted in subsection H of this section, be performed through commercial banks, savings and loan associations and private mortgage bankers approved as servicing agents ("servicing agents") of the authority~~ be performed by the authority.

B. To be initially approved as an originating ~~agent or as a servicing agent~~ lender and to continue to be so approved, the applicant must meet the following qualifications:

1. Be authorized to do business in the Commonwealth of Virginia and be licensed as a mortgage lender or broker, as applicable, under the Virginia Mortgage Lender and Broker Act as set forth in Chapter 16 (§ ~~6.1-408~~ 6.2-1600 et seq.) of Title ~~6.1~~ 6.2 of the Code of Virginia (including nonprofit corporations that may be exempt from licensing when making mortgage loans on their own behalf under subdivision 4 of § ~~6.1-411~~ 6.2-1602 of the Code of Virginia); provided, however, that such licensing requirement shall not apply to persons exempt from licensure under:

a. Subdivision 2 of § ~~6.1-411~~ 6.2-1602 of the Code of Virginia (any person subject to the general supervision of or subject to examination by the Commissioner of the Bureau of Financial Institutions of the Virginia State Corporation Commission);

b. Subdivision 3 of § ~~6.1-411~~ 6.2-1602 of the Code of Virginia (any lender authorized to engage in business as a bank, savings institution, or credit union under the laws of the United States~~,~~ or any state ~~or territory of the United States, or the District of Columbia~~, and subsidiaries and affiliates of such entities~~,~~ which lender, subsidiary or affiliate is subject to the general supervision or regulation of or subject to audit or examination by a regulatory body or agency of the United States~~,~~ or any ~~state or territory of the United States, or the District of Columbia)~~ state); or

c. Subdivision 5 of § ~~6.1-411~~ 6.2-1602 of the Code of Virginia (agencies of the federal government, or any state or municipal government, or any quasi-governmental agency making or brokering mortgage loans under the specific authority of the laws of any state or the United States) [~~,~~]

2. Have a net worth equal to or in excess of ~~$500,000 or such other amount as the executive director shall from time to time deem appropriate~~ requirements mandated by FHA or any other guarantor or investor, as applicable to the programs in which the originating lender participates, except that this qualification requirement shall not apply to redevelopment and housing authorities and agencies of local government;

3. Have a staff with demonstrated ability and experience in mortgage loan origination, underwriting, processing, and closing ~~(in the case of an originating agent applicant) or servicing (in the case of a servicing agent applicant)~~;

4. ~~To be approved as an originating agent, have~~ Have a physical office located in Virginia that is open to the general public during commercially reasonable business hours, staffed with individuals qualified to take mortgage loan applications, and to which the general public may physically go to make an application for a mortgage loan, unless the executive director determines that it is reasonable or necessary to waive or modify such requirement after taking into consideration current industry and market conditions;

5. ~~To be approved as an originating agent, be~~ Be eligible to, and have a staff qualified to (as set forth in subdivision 3 of this subsection), originate mortgage loans under all of the authority's [~~single family~~ single family] mortgage loan programs (not including the Rural Development loan program), unless otherwise approved for originating lenders originating mortgage loans in underserved markets;

6. Have a fidelity bond and mortgage errors and omissions coverage in an amount at least equal to ~~$500,000~~ requirements mandated by FHA or any other guarantor or investor as applicable to the programs in which the originating lender participates and provide the authority a certificate from the insurance carrier naming the authority as a party in interest to the bond, or the policies or bonds shall name the authority as one of the parties insured. The policy's deductible clause ~~may be for any amount up to the greater of $100,000 or 5.0% of the face amount of the policy~~ must also meet the requirements mandated by FHA or any other guarantor or investor as applicable to the programs in which the originating lender participates;

7. Have a past history of satisfactory performance in the authority's and other mortgage lenders', insurers', guarantors', and investors' mortgage programs that, in the determination of the executive director, demonstrates that the applicant will be capable of meeting its obligations under the authority's programs, and provided further that, any applicant that has been previously terminated as an originating lender by the ~~Authority~~ authority shall not be eligible to reapply for 24 months after the effective date of such termination; and

8. Meet such other qualifications as the executive director shall deem to be related to the performance of its duties and responsibilities.

The executive director may modify or waive any of the requirements in this subsection if he determines (i) that it is reasonable or necessary to do so after taking into consideration any mitigating factors and (ii) that the financial interests of the authority are adequately protected. In making this determination, the executive director may require such other requirements as he deems reasonable or necessary to adequately protect the financial interests of the authority.

~~Notwithstanding the foregoing, in~~ In the event that the executive director determines that it is reasonable or necessary (after taking into consideration the number of existing ~~origination and servicing agents~~ originating lenders, the current and expected level of loan production and demand for mortgage loans, and the current and expected resources available to the authority to make mortgage loans) to cease approving additional originating ~~and servicing agents~~ lenders, the authority may at any time decline to accept further applications and to approve applications previously submitted.

C. Each originating ~~agent~~ lender approved by the authority shall enter into ~~an originating~~ a purchase agreement ~~("originating agreement"),~~ with the authority ~~containing such terms and conditions as the executive director shall require with respect to the origination and processing of mortgage loans hereunder. Each servicing agent approved by the authority shall enter into a servicing agreement with the authority containing such terms and conditions as the executive director shall require with respect to the servicing of mortgage loans.~~

~~An applicant may be approved as both an originating agent and a servicing agent ("originating and servicing agent"). Each originating and servicing agent shall enter into both an originating agreement and a servicing agreement.~~

Once ~~such agreements are~~ the purchase agreement is executed, continued participation in the authority's programs shall be subject to the terms and conditions in ~~such agreements~~ the agreement.

~~For the purposes of this chapter, the term "originating agent" shall hereinafter be deemed to include the term "originating and servicing agent," unless otherwise noted or the context indicates otherwise. The term "servicing agent" shall continue to mean an agent authorized only to service mortgage loans.~~

D. Originating ~~agents and servicing agents~~ lenders shall maintain adequate books and records with respect to mortgage loans which they originate and ~~process or service, as applicable~~ sell to the authority, shall permit the authority to examine such books and records, and shall submit to the authority such reports (including annual financial statements) and information as the authority may require. The fees payable to the originating ~~agents and servicing agents~~ lenders for originating and ~~processing or for servicing~~ selling mortgage loans ~~hereunder~~ shall be established from time to time by the executive director and shall be set forth in the ~~originating agreements and servicing agreements applicable to such originating agents and servicing agents~~ origination guide.

~~B.~~ E. The executive director shall allocate funds for the making or financing of mortgage loans ~~hereunder~~ in such manner, to such persons and entities, in such amounts, for such period, and subject to such terms and conditions as he shall deem appropriate to best accomplish the purposes and goals of the authority. Without limiting the foregoing, the executive director may allocate funds (i) to mortgage loan applicants on a first-come, first-serve or other basis, (ii) to originating ~~agents~~ lenders and state and local government agencies and instrumentalities for the origination of mortgage loans to qualified applicants ~~and/or,~~ (iii) to builders for the permanent financing of residences constructed or rehabilitated or to be constructed or rehabilitated by them and to be sold to qualified applicants, or (iv) for permanent or interim construction or renovation financing of eligible properties to be sold to qualified applicants. In determining how to ~~so~~ allocate the funds, the executive director may consider such factors as he deems relevant, including any of the following:

1. The need for the expeditious commitment and disbursement of such funds for mortgage loans;

2. The need and demand for the financing of mortgage loans with such funds in the various geographical areas of the Commonwealth;

3. The cost and difficulty of administration of the allocation of funds;

4. The capability, history, and experience of any originating ~~agents~~ lenders, state and local governmental agencies and instrumentalities, builders, or other persons and entities (other than mortgage loan applicants) who are to receive an allocation; and

5. Housing conditions in the Commonwealth.

F. In the event that the executive director shall determine to make allocations of funds to builders as described ~~above~~ in subsection E of this section, the ~~following requirements must be satisfied by each such builder:~~

~~1. The builder must have a valid contractor's license in the Commonwealth;~~

~~2. The builder must have at least three years' experience of a scope and nature similar to the proposed construction or rehabilitation; and~~

~~3. The builder must submit to the authority plans and specifications for the proposed construction or rehabilitation~~

~~which are acceptable to the authority.~~ builder shall satisfy the requirements as the executive director shall establish with respect to builder qualifications.

G. The executive director may from time to time take such action as he may deem necessary or proper in order to solicit applications for allocation of funds ~~hereunder~~. Such actions may include advertising in newspapers and other media, mailing of information to prospective applicants and other members of the public, and any other methods of public announcement ~~which~~ that the executive director may select as appropriate under the circumstances. The executive director may impose requirements, limitations, and conditions with respect to the submission of applications as he shall consider necessary or appropriate. The executive director may cause market studies and other research and analyses to be performed in order to determine the manner and conditions under which funds of the authority are to be allocated and such other matters as he shall deem appropriate relating thereto. The authority may also consider and approve applications for allocations of funds submitted from time to time to the authority without any solicitation therefor on the part of the authority.

~~C. This chapter constitutes a portion of the originating guide of the authority. The originating guide and all exhibits and other documents referenced herein are not included in, and shall not be deemed to be a part of this chapter.~~ H. The executive director is authorized to prepare and from time to time revise an ~~originating~~ origination guide ~~and a servicing guide which shall set forth the accounting and other procedures to be followed by all originating agents and servicing agents responsible for the origination, closing and servicing of mortgage loans under the applicable originating agreements and servicing agreements~~. Copies of the ~~originating~~ origination guide ~~and the servicing guide~~ shall be available upon request. The executive director shall be responsible for the implementation and interpretation of the provisions of the ~~originating~~ origination guide ~~(including the originating guide) and the servicing guide~~.

~~D.~~ I. The authority may from time to time (i) make mortgage loans directly to mortgagors with the assistance and services of its originating ~~agents and~~ lenders, (ii) agree to purchase individual mortgage loans from its originating ~~agents or servicing agents~~ lenders upon the consummation of the closing thereof, and (iii) make mortgage loans directly to mortgagors in underserved markets. The review and processing of applications for such mortgage loans, the issuance of mortgage loan ~~commitments therefor~~ approvals, the closing ~~and servicing (and,~~ and, if applicable, the ~~purchase)~~ purchase of such mortgage loans, and the terms and conditions relating to such mortgage loans shall be governed by and shall comply with the provisions of the ~~applicable originating~~ purchase agreement ~~or servicing agreement~~, the ~~originating~~ origination guide, ~~the servicing guide,~~ the Act, and this chapter.

J. If the applicant and the application for a mortgage loan meet the requirements of the Act and this chapter, the ~~executive director~~ authority may issue ~~on behalf of the authority~~ a mortgage loan ~~commitment~~ approval to the applicant for the financing of the single family dwelling unit. Such mortgage loan commitment shall be issued only upon the determination of the authority that such a mortgage loan is not otherwise available from private lenders upon reasonably equivalent terms and conditions, and such determination shall be set forth in the mortgage loan ~~commitment~~ approval. The original principal amount and term of such mortgage loan, the amortization period, the terms and conditions relating to the prepayment thereof, and such other terms, conditions, and requirements as the executive director deems necessary or appropriate shall be set forth or incorporated in the mortgage loan ~~commitment~~ approval issued on behalf of the authority with respect to such mortgage loan.

~~E. The authority may purchase from time to time existing mortgage loans with funds held or received in connection with bonds issued by the authority prior to January 1, 1981, or with other funds legally available therefor. With respect to any such purchase, the executive director may request and solicit bids or proposals from the authority's originating agents and servicing agents for the sale and purchase of such mortgage loans, in such manner, within such time period and subject to such terms and conditions as he shall deem appropriate under the circumstances. The sales prices of the single family housing units financed by such mortgage loans, the gross family incomes of the mortgagors thereof, and the original principal amounts of such mortgage loans shall not exceed such limits as the executive director shall establish, subject to approval or ratification by resolution of the board. The executive director may take such action as he deems necessary or appropriate to solicit offers to sell mortgage loans, including mailing of the request to originating agents and servicing agents, advertising in newspapers or other publications and any other method of public announcement which he may select as appropriate under the circumstances. After review and evaluation by the executive director of the bids or proposals, he shall select those bids or proposals that offer the highest yield to the authority on the mortgage loans (subject to any limitations imposed by law on the authority) and that best conform to the terms and conditions established by him with respect to the bids or proposals. Upon selection of such bids or proposals, the executive director shall issue commitments to the selected originating agents and servicing agents to purchase the mortgage loans, subject to such terms and conditions as he shall deem necessary or appropriate. Upon satisfaction of the terms of the commitments, the executive director shall execute such agreements and documents and take such other action as may be necessary or appropriate in order to consummate the purchase and sale of the mortgage loans. The mortgage loans so purchased shall be serviced in accordance with the applicable originating agreement or servicing agreement and the servicing guide.~~

~~Such mortgage loans and the purchase thereof shall in all respects comply with the Act and the authority's rules and regulations.~~

~~F.~~ K. The executive director may, in his discretion, delegate to one or more originating ~~agents~~ lenders all or some of the responsibility for underwriting, issuing ~~commitments~~ approvals for mortgage loans, and disbursing the proceeds ~~hereof~~ without prior review and approval by the authority. ~~The executive director may delegate to one or more servicing agents all or some of the responsibility for underwriting and issuing commitments for the assumption of existing authority mortgage loans without prior review and approval by the authority.~~ If the executive director determines to make any such delegation, he shall establish criteria under which originating ~~agents~~ lenders may qualify for such delegation. If such delegation has been made, the originating ~~agents~~ lenders shall submit all required documentation to the authority at such time as the authority may require. If the executive director determines that a mortgage loan does not comply with any requirement under the ~~originating~~ origination guide, the applicable ~~originating~~ purchase agreement, the Act, or this chapter for which the originating ~~agent~~ lender was delegated responsibility, he may require the originating ~~agents~~ lender to purchase such mortgage loan, subject to such terms and conditions as he may prescribe.

~~G.~~ L. The authority may utilize ~~financial institutions, mortgage brokers and other private firms and individuals and governmental entities ("field originators") approved by the authority~~ originating agents for the purpose of receiving applications for mortgage loans. To be approved as ~~a field originator~~ an originating agent, the applicant must meet the following qualifications:

1. Be authorized to do business in the Commonwealth of Virginia~~;~~ and be licensed as a mortgage lender or broker, as applicable, under the Virginia Mortgage Lender and Broker Act as set forth in Chapter 16 (§ 6.2-1600 et seq.) of Title 6.2 of the Code of Virginia (including nonprofit corporations that may be exempt from licensing when making mortgage loans on their own behalf under subdivision 4 of § 6.2-1602 of the Code of Virginia); provided, however that such licensing requirement shall not apply to persons exempt from licensure under:

a. Subdivision 2 of § 6.2-1602 of the Code of Virginia (any person subject to the general supervision of or subject to examination by the Commissioner of the Bureau of Financial Institutions of the Virginia State Corporation Commission);

b. Subdivision 3 of § 6.2-1602 of the Code of Virginia (any lender authorized to engage in business as a bank, savings institution, or credit union under the laws of the United States or any state, and subsidiaries and affiliates of such entities which lender, subsidiary or affiliate is subject to the general supervision or regulation of or subject to audit or examination by a regulatory body or agency of the United States or any state); or

c. Subdivision 5 of § 6.2-1602 of the Code of Virginia (agencies of the federal government, or any state or municipal government, or any quasi-governmental agency making or brokering mortgage loans under the specific authority of the laws of any state or the United States);

~~2. Have made any necessary filings or registrations and have received any and all necessary approvals or licenses in order to receive applications for mortgage loans in the Commonwealth of Virginia;~~

~~3.~~ 2. Have the demonstrated ability and experience in the receipt and processing of mortgage loan applications; and

~~4.~~ 3. Have such other qualifications as the executive director shall deem to be related to the performance of its duties and responsibilities.

Each ~~field originator~~ originating agent approved by the authority shall enter into such agreement as the executive director shall require with respect to the receipt of applications for mortgage loans. ~~Field originators~~ Originating agents shall perform ~~such of~~ the duties and responsibilities of originating ~~agents~~ lenders under this chapter as the authority may require in such agreement.

~~Field originators~~ M. Originating agents shall maintain adequate books and records with respect to mortgage loans for which they accept applications, shall permit the authority to examine such books and records, and shall submit to the authority such reports and information as the authority may require. The fees to the ~~field originators~~ originating agents for accepting applications shall be payable in such amount and at such time as the executive director shall determine.

N. In the case of mortgage loans for which applications are received by ~~field originators~~ originating agents, the authority may process and originate the mortgage loans; accordingly, unless otherwise expressly provided, the provisions of this chapter requiring the performance of any action by originating ~~agents~~ lenders shall not be applicable to the origination and processing by the authority of such mortgage loans, and any or all of such actions may be performed by the authority on its own behalf.

~~H. The authority may service mortgage loans for which the applications were received by field originators or any mortgage loan which, in the determination of the authority, originating agents and servicing agents will not service on terms and conditions acceptable to the authority or for which the originating agent or servicing agent has agreed to terminate the servicing thereof.~~

Part II
Program Requirements

13VAC10-40-30. Eligible persons and citizenship.

A. One person or multiple persons are eligible to be a borrower ~~or borrowers~~ of a single family loan if such person or all such persons satisfy the criteria and requirements in ~~these rules and regulations~~ this chapter. All references in ~~these rules and regulations~~ this chapter to an applicant or borrower shall, in the case of multiple applicants or borrowers, be deemed to refer to each applicant or borrower individually, unless the provision containing such reference expressly refers to the applicants or borrowers collectively.

B. Each applicant for an authority mortgage loan must either be a United States citizen, a lawful permanent resident alien as determined by the U.S. ~~Department of Immigration and Naturalization Service~~ Citizenship and Immigration Services or a nonpermanent resident alien provided the applicant has a social security number and is eligible to work in the United States. In addition, applicants must meet any stricter citizenship or residency requirements of the insurer, guarantor, or investor with respect to the applicable authority loan program.

C. Each applicant must be 18 years of age or older or have been declared emancipated by order or decree of a court having jurisdiction.

13VAC10-40-40. Compliance with certain requirements of ~~the Internal Revenue Code of 1986, as amended ("the tax code").~~

A. The tax code imposes certain requirements and restrictions on the eligibility of mortgagors and residences for (i) the financing with the proceeds of tax-exempt bonds (as well as requirements and restrictions on the assumption of mortgage loans so financed); and (ii) the issuance of mortgage credit certificates.

B. The authority requires the following:

1. The mortgage revenue bond residence requirements;

2. The requirement that each applicant must not have had a present ownership interest in his principal residence within the preceding three years (the first-time homebuyer or three-year requirement); and

3. The mortgage revenue bond income requirements.

Notwithstanding the foregoing, certain authority loan programs described in 13VAC10-40-230, 13VAC10-40-250, 13VAC10-40-260, and 13VAC10-40-270 contain exceptions to the mortgage revenue bond requirements in this subsection.

C. In order to comply with these federal requirements and restrictions, as well as other authority requirements, the authority has established [that] certain procedures ~~which~~ must be performed by the originating ~~agent~~ lender in order to determine such eligibility. The eligibility requirements for ~~the~~ each borrower ~~or the borrowers and,~~ the dwelling, and the procedures to be performed are described ~~below as well as the procedures to be performed~~ in this subsection. The originating ~~agent~~ lender will perform these procedures and evaluate ~~a~~ each borrower's ~~or borrowers'~~ eligibility prior to the authority's approval of each loan. No loan will be approved by the authority unless all of the federal eligibility requirements are met as well as the usual requirements of the authority set forth [in] ~~other parts of~~ this ~~originating~~ chapter and the origination guide, unless the executive director determines that it is reasonable or necessary to waive or modify any such requirements and that the financial interests of the authority are adequately protected.

~~The~~ In addition to the three mortgage revenue bond requirements set forth in subsection B of this section, the executive director may apply some or all of the ~~above-referenced tax-exempt~~ other tax-exempt bond requirements and restrictions set forth in the tax code to authority mortgage loans ~~that are not funded with tax-exempt bonds if the executive director determines that such requirement and restrictions are necessary~~ to enable the authority to effectively and efficiently allocate its current and anticipated financial resources so as to best meet the current and future housing needs of ~~the citizens throughout the Commonwealth~~ low and moderate income Virginians.

13VAC10-40-50. Eligible borrowers.

A. In order to be considered eligible for an authority mortgage loan, an applicant must, among other things, meet all of the following ~~federal~~ criteria:

1. Each applicant must not have had a present ownership interest in his principal residence within the three years preceding the date of execution of the mortgage loan documents (see subsection B of this section);

2. Each applicant must agree to occupy and use the residential property to be purchased as his permanent, principal residence within 60 days ~~(90 days~~, or such longer amount of time as the executive director determines is reasonable in the case of a purchase and rehabilitation loan ~~as described in 13VAC10-40-200),~~ after the date of the closing of the mortgage loan (see subsection C of this section);

~~3. Each applicant must not use the proceeds of the mortgage loan to acquire or replace an existing mortgage or debt, except in the case of certain types of temporary financing (see subsection D of this section);~~

~~4.~~ 3. Each applicant must have contracted to purchase an eligible dwelling (see 13VAC10-40-60, Eligible dwellings);

~~5.~~ 4. Each applicant must execute an affidavit of borrower (Exhibit ~~E)~~ E2) at the time of loan application; and

~~6. The~~ 5. No applicant ~~or applicants must not~~ may receive income in an amount in excess of the applicable federal income limit imposed by the tax code (see 13VAC10-40-100, Maximum gross income)~~;~~.

~~7. Each applicant must agree not to sell, lease or otherwise transfer an interest in the residence or permit the assumption of his mortgage loan unless certain requirements are met (see 13VAC10-40-140, Loan assumptions); and~~

~~8. Each applicant must be over the age of 18 years or have been declared emancipated by order or decree of a court having jurisdiction.~~

B. An eligible borrower does not include any borrower who, at any time during the three years preceding the date of execution of the mortgage loan documents, had a ~~"~~present ownership interest~~" (as hereinafter defined)~~ in his principal residence. Each borrower must certify on the affidavit of borrower that at no time during the three years preceding the execution of the mortgage loan documents has he had a present ownership interest in his principal residence. This requirement does not apply to residences located in "targeted areas" (see 13VAC10-40-70, Targeted areas)~~; however, even if the residence is located in a "targeted area," the tax returns for the most recent taxable year (or the letter described in subdivision 3 below) must be obtained for the purpose of determining compliance with other requirements~~.

~~1. "Present ownership interest" includes:~~

~~a. A fee simple interest;~~

~~b. A joint tenancy, a tenancy in common, or a tenancy by the entirety;~~

~~c. The interest of a tenant shareholder in a cooperative;~~

~~d. A life estate;~~

~~e. A land contract, under which possession and the benefits and burdens of ownership are transferred although legal title is not transferred until some later time; and~~

~~f. An interest held in trust for the eligible borrower (whether or not created by the eligible borrower) that would constitute a present ownership interest if held directly by the eligible borrower.~~

~~Interests which do not constitute a present ownership interest include:~~

~~a. A remainder interest;~~

~~b. An ordinary lease with or without an option to purchase;~~

~~c. A mere expectancy to inherit an interest in a principal residence;~~

~~d. The interest that a purchaser of a residence acquires on the execution of an accepted offer to purchase real estate; and~~

~~e. An interest in other than a principal residence during the previous three years.~~

[~~2.~~ 1.] ~~This requirement~~ The present ownership interest limitation applies to any person who will execute the mortgage document or note and will have a present ownership interest ~~(as defined above)~~ in the eligible dwelling.

[~~3.~~ 2.] To verify that each eligible borrower meets the three-year requirement, the originating ~~agent~~ lender must obtain ~~copies of signed federal income tax returns filed by the eligible borrower for the three tax years immediately preceding execution of the mortgage documents (or certified copies of the returns) or a copy of a letter from the Internal Revenue Service stating that its Form 1040A or 1040EZ was filed by the eligible borrower for any of the three most recent tax years for which copies of such returns are not obtained. If the eligible borrower was not required by law to file a federal income tax return for any of these three years and did not so file, and so states on the borrower affidavit, the requirement to obtain a copy of the federal income tax return or letter from the Internal Revenue Service for such year or years is waived~~: (i) the fully executed affidavit of borrower (Exhibit E2) signed by all borrowers and nonborrower occupants taking title; (ii) a completed Uniform Residential Loan Application [, Freddie Mac Form 65/Fannie Mae Form 1003] (Form 1003); and (iii) the credit report. If the originating lender is unable to confirm from the affidavit of borrower, Form 1003, or the credit report that the borrowers or nonborrower occupants taking title meet the three-year requirement, additional documentation may be required, such as three years of federal tax returns or tax transcripts, rent verification, and other reports.

~~The~~ If reviewing tax returns or tax transcripts, the originating ~~agent~~ lender shall examine the tax returns or tax transcripts particularly for any evidence that an eligible borrower may have claimed deductions for property taxes or for interest on indebtedness with respect to real property constituting his principal residence.

[~~4.~~ 3.] The originating ~~agent~~ lender must, with due diligence, verify the representations in the affidavit of borrower (Exhibit ~~E)~~ E2) regarding each eligible borrower's prior residency by reviewing any information including the Form 1003, a credit report ~~and the,~~ tax returns ~~furnished by each eligible borrower~~ or tax transcripts, rent verification, and other reports for consistency [~~,~~] and make a determination that on the basis of its review each borrower has not had present ownership interest in a principal residence at any time during the

three-year period prior to the anticipated date of the loan closing.

C. Each eligible borrower must intend at the time of closing to occupy the eligible dwelling as a principal residence within 60 days ~~(90 days~~ (or such longer amount of time as the executive director determines is reasonable in the case of a purchase and rehabilitation loan) after the closing of the mortgage loan. Unless the residence can reasonably be expected to become the principal residence of each eligible borrower within 60 days ~~(90 days~~ (or such longer amount of time as the executive director determines is reasonable in the case of a purchase and rehabilitation loan) of the mortgage loan closing date, the residence will not be considered an eligible dwelling and may not be financed with a mortgage loan from the authority. Each eligible borrower must covenant to intend to occupy the eligible dwelling as a principal residence within 60 days ~~(90 days~~ (or such longer amount of time as the executive director determines is reasonable in the case of a purchase and rehabilitation loan) after the closing of the mortgage loan on the affidavit of borrower (to be updated at the closing of the mortgage loan) and as part of the attachment to the deed of trust.

1. A principal residence does not include any residence ~~which~~ that can reasonably be expected to be used: (i) primarily in a trade or business, (ii) as an investment property, or (iii) as a recreational or second home. A residence may not be used in a manner ~~which~~ that would permit any portion of the costs of the eligible dwelling to be deducted as a trade or business expense for federal income tax purposes or under circumstances where more than 15% of the total living area is to be used primarily in a trade or business.

2. The land financed by the mortgage loan may not provide, other than incidentally, a source of income to an eligible borrower. Each eligible borrower must indicate on the affidavit of borrower that, among other things:

a. No portion of the land financed by the mortgage loan provides a source of income (other than incidental income);

b. He does not intend to farm any portion (other than as a garden for personal use) of the land financed by the mortgage loan; and

c. He does not intend to subdivide the property.

3. Only such land as is reasonably necessary to maintain the basic ~~liveability~~ livability of the residence may be financed by a mortgage loan. The financed land must not exceed the customary or usual lot in the area. Generally, the financed land will not be permitted to exceed two acres, even in rural areas. However, exceptions may be made to permit lots larger than two acres, but in no event in excess of five acres: (i) if the land is owned free and clear and is not being financed by the loan, the lot may be as large as five acres, (ii) if difficulty is encountered locating a well or septic field, the lot may include the additional acreage needed, (iii) local city and county ordinances ~~which~~ that require more acreage will be taken into consideration, or (iv) if the lot size is determined by the authority, based upon objective information provided by the borrower, to be usual and customary in the area for comparably priced homes. The executive director may modify or waive such requirements if he determines that it is reasonable or necessary to do so and that the financial interests of the authority are adequately protected.

4. The affidavit of borrower (Exhibit ~~E)~~ E2) must be reviewed by the originating ~~agent~~ lender for consistency with each eligible borrower's ~~federal income tax returns and the credit report~~ Form 1003, credit report, tax returns or tax transcripts, rent verifications, and other reports, and the originating ~~agent~~ lender must, based on such review, make a determination that each borrower has not used any previous residence or any portion thereof primarily in any trade or business.

5. The originating ~~agent~~ lender shall establish procedures to (i) review correspondence, checks, and other documents received from ~~the~~ each borrower ~~or borrowers~~ during the 120-day period following the loan closing for the purpose of ascertaining that the address of the residence and the address of ~~the~~ each borrower ~~or borrowers~~ are the same and (ii) notify the authority if such addresses are not the same. Subject to the authority's approval, the originating ~~agent~~ lender may establish different procedures to verify compliance with this requirement.

~~D. Mortgage loans may be made only to an eligible borrower who did not have a mortgage (whether or not paid off) on the eligible dwelling at any time prior to the execution of the mortgage. Mortgage loan proceeds may not be used to acquire or replace an existing mortgage or debt for which an eligible borrower is liable or which was incurred on behalf of an eligible borrower, except in the case of construction period loans, bridge loans or similar temporary financing which has a term of 24 months or less.~~

~~1. For purposes of applying the new mortgage requirement, a mortgage includes deeds of trust, conditional sales contracts (i.e. generally a sales contract pursuant to which regular installments are paid and are applied to the sales price), pledges, agreements to hold title in escrow, a lease with an option to purchase which is treated as an installment sale for federal income tax purposes and any other form of owner financing. Conditional land sale contracts shall be considered as existing loans or mortgages for purposes of this requirement.~~

~~2. In the case of a mortgage loan (having a term of 24 months or less) made to refinance a loan for the construction of an eligible dwelling, the authority shall not~~

~~make such mortgage loan until it has determined that such construction has been satisfactorily completed.~~

~~3. Prior to closing the mortgage loan, the originating agent must examine the affidavit of borrower (Exhibit E), the affidavit of seller (Exhibit F), and related submissions, including (i) each eligible borrower's federal income tax returns for the preceding three years, and (ii) credit report, in order to determine whether the eligible borrower will meet the new mortgage requirements. Based upon such review, the originating agent shall make a determination that the proceeds of the mortgage loan will not be used to repay or refinance an existing mortgage debt of any borrower and that each borrower did not have a mortgage loan on the eligible dwelling prior to the date hereof, except for permissible temporary financing described above.~~

~~E.~~ D. Any eligible borrower may not have more than one outstanding authority first mortgage loan.

13VAC10-40-60. Eligible dwellings.

~~A.~~ In order to qualify as an eligible dwelling for which an authority loan may be made, the residence must:

1. Be located in the Commonwealth;

2. Be a [~~one family~~ single family] detached residence, a ~~townhouse~~ [~~one-family~~ single family] attached residence, or one unit of ~~an authority approved~~ a condominium meeting the requirements of the authority;

~~3. Satisfy the acquisition cost requirements set forth below;~~ and

~~4.~~ 3. Be owned or to be owned by the applicant in the form of fee simple interest.

The authority may decline to finance more than 25% of the units in any one condominium project, planned unit development (PUD), or subdivision if the executive director determines that financing additional units would be detrimental to the authority's financial interests after taking into consideration the ~~then~~ current and expected demand and supply of housing in the applicable geographic region.

~~B. The acquisition cost of an eligible dwelling may not exceed certain limits established by the U.S. Department of the Treasury in effect at the time of the application. Note: In all cases for new loans such federal limits equal or exceed the authority's sales price limits shown in 13VAC10-40-80. Therefore, for new loans the residence is an eligible dwelling if the acquisition cost is not greater than the authority's sales price limit. In the event that the acquisition cost exceeds the authority's sales price limit, the originating agent must contact the authority to determine if the residence is an eligible dwelling.~~

~~1. To determine if the acquisition cost is at or below the federal limits for assumptions, the originating agent or, if applicable, the servicing agent must in all cases contact the authority (see 13VAC10-40-140).~~

~~2. Acquisition cost means the cost of acquiring the eligible dwelling from the seller as a completed residence.~~

~~a. Acquisition cost includes:~~

~~(1) All amounts paid, either in cash or in kind, by the eligible borrower (or a related party or for the benefit of an eligible borrower) to the seller (or a related party or for the benefit of the seller) as consideration for the eligible dwelling. Such amounts include amounts paid for items constituting fixtures under state law, but not for items of personal property not constituting fixtures under state law. (See Exhibit R for examples of fixtures and items of personal property.)~~

~~(2) The reasonable costs of completing or rehabilitating the residence (whether or not the cost of completing construction or rehabilitation is to be financed with the mortgage loan) if the eligible dwelling is incomplete or is to be rehabilitated. As an example of reasonable completion cost, costs of completing the eligible dwelling so as to permit occupancy under local law would be included in the acquisition cost. A residence which includes unfinished areas (i.e. an area designed or intended to be completed or refurbished and used as living space, such as the lower level of a tri-level residence or the upstairs of a Cape Cod) shall be deemed incomplete, and the costs of finishing such areas must be included in the acquisition cost.~~

~~(3) The cost of land on which the eligible dwelling is located and which has been owned by an eligible borrower for a period no longer than two years prior to the construction of the structure comprising the eligible dwelling.~~

~~b. Acquisition cost does not include:~~

~~(1) Usual and reasonable settlement or financing costs. Such excluded settlement costs include title and transfer costs, title insurance, survey fees and other similar costs. Such excluded financing costs include credit reference fees, legal fees, appraisal expenses, points which are paid by an eligible borrower, or other costs of financing the residence. Such amounts must not exceed the usual and reasonable costs which otherwise would be paid. Where the buyer pays more than a pro rata share of property taxes, for example, the excess is to be treated as part of the acquisition cost.~~

~~(2) The imputed value of services performed by an eligible borrower or members of his family (brothers and sisters, spouse, ancestors and lineal descendants) in constructing or completing the residence.~~

~~3. The originating agent is required to obtain from each eligible borrower a completed affidavit of borrower which~~

~~shall include a calculation of the acquisition cost of the eligible dwelling in accordance with this subsection B. The originating agent shall assist each eligible borrower in the correct calculation of such acquisition cost. The affidavit of seller shall also certify as to the acquisition cost of the eligible dwelling.~~

~~4. The originating agent shall for each new loan determine whether the acquisition cost of the eligible dwelling exceeds the authority's applicable sales price limit shown in 13VAC10-40-80. If the acquisition cost exceeds such limit, the originating agent must contact the authority to determine if the residence is an eligible dwelling for a new loan. (For an assumption, the originating agent or, if applicable, the servicing agent must contact the authority for this determination in all cases, see 13VAC10-40-140). Also, as part of its review, the originating agent must review the affidavit of borrower submitted by each mortgage loan applicant and must make a determination that the acquisition cost of the eligible dwelling has been calculated in accordance with this subsection B. In addition, the originating agent must compare the information contained in the affidavit of borrower with the information contained in the affidavit of seller and other sources and documents such as the contract of sale for consistency of representation as to acquisition cost.~~

~~5. The authority reserves the right to obtain an independent appraisal in order to establish fair market value and to determine whether a dwelling is eligible for the mortgage loan requested.~~

The authority may finance a dwelling located on land owned by a community land trust, provided that (i) the first mortgage loan is secured by a leasehold estate on the property owned by the community land trust and a fee simple interest in the improvements on the property; (ii) the dwelling and the first mortgage loan meet all applicable insurer, guarantor, or investor requirements; and (iii) the term of the leasehold estate created by the ground lease must extend for at least five years beyond the maturity date of the first mortgage loan.

13VAC10-40-70. Targeted areas.

~~A. In accordance with the tax code, the authority will make a portion of the proceeds of an issue of its bonds available for financing eligible dwellings located in targeted areas for at least one year following the issuance of a series of bonds. The authority will exercise due diligence in making mortgage loans in targeted areas by advising originating agents and certain localities of the availability of such funds in targeted areas and by advising potential eligible borrowers of the availability of such funds through advertising and/or news releases. The amount, if any, allocated to an originating agent exclusively for targeted areas will be specified in a forward commitment agreement between the originating agent and the authority.~~

~~B.~~ Mortgage loans for eligible dwellings located in targeted areas ~~must comply in all respects with the requirements in 13VAC10-40-40 and elsewhere in this guide for all mortgage loans, except for~~ do not need to meet the three-year requirement described in 13VAC10-40-50 B. ~~Notwithstanding this exception, each applicant must still submit certain federal income tax records. However, they will be used to verify income and to verify that previously owned residences have not been primarily used in a trade or business (and not to verify nonhomeownership), and only those records for the most recent year preceding execution of the mortgage documents (rather than the three most recent years) are required. See that section for the specific type of records to be submitted.~~

~~The following definitions are applicable to targeted areas.~~

~~1. A targeted area is an area which is a qualified census tract, as described in b below, or an area of chronic economic distress, as described in c below.~~

~~2. A qualified census tract is a census tract in the Commonwealth in which 70% or more of the families have an income of 80% or less of the state-wide median family income based on the most recent "safe harbor" statistics published by the U.S. Treasury.~~

~~3. An area of chronic economic distress is an area designated as such by the Commonwealth and approved by the Secretaries of Housing and Urban Development and the Treasury under criteria specified in the tax code. PDS agents will be informed by the authority as to the location of areas so designated.~~

13VAC10-40-80. Sales price limits.

A. The executive director shall, from time to time, establish the applicable maximum allowable sales prices. Each such maximum allowable sales price shall be expressed as a percentage of the applicable maximum purchase price permitted or approved by the U.S. Department of the Treasury pursuant to the federal tax code or as a dollar amount, which percentage or dollar amount may vary by loan program and geographic region as determined by the executive director, after taking into consideration such factors as he deems appropriate, including, without limitation, the following factors:

1. The current and anticipated financial resources available to the authority to make mortgage loans;

2. The current and anticipated financial resources available to potential applicants from sources other than the authority to finance mortgage loans;

3. The current and anticipated demand for mortgage loans;

4. The prevailing mortgage loan terms available to potential applicants; and

5. The current and anticipated need for targeted or subsidized lending in each region based upon financial conditions and the housing market in such region.

B. The executive director shall apply the ~~foregoing~~ factors in subsection A of this section to establish the maximum allowable sales prices that enable the authority to effectively and efficiently allocate its current and anticipated financial resources so as to best meet the current and future housing needs of the citizens throughout the Commonwealth.

The authority shall from time to time inform its originating ~~agents and servicing agents~~ lenders by written notification ~~thereto~~ of the ~~foregoing~~ maximum allowable sales prices under this section expressed in dollar amounts for each area of the state, as established by the executive director. Any changes to the dollar amounts of such maximum allowable sales prices shall be effective as of such date as the executive director shall determine (subject to any exceptions for ~~pending loan reservations or applications~~ locked loans as the executive director may determine), and ~~authority is reserved to~~ the executive director ~~to~~ may implement any such changes on such date ~~or dates~~ as he shall deem necessary or appropriate to best accomplish the purposes of the program.

13VAC10-40-90. Net worth.

To be eligible for authority financing, ~~the~~ no applicant ~~or applicants cannot~~ may have a net worth exceeding 50% of the sales price of the eligible dwelling. (The value of life insurance policies, retirement plans, furniture, and household goods shall not be included in determining net worth.) In addition, the portion of ~~the~~ an applicant's ~~or applicants'~~ liquid assets ~~which~~ that are used to make the down payment and to pay closing costs, up to a maximum of 25% of the sale price, will not be included in the net worth calculation.

Any income producing assets needed as a source of income in order to meet the minimum income requirements for an authority loan will not be included in ~~the~~ an applicant's ~~or applicants'~~ net worth for the purpose of determining whether this net worth limitation has been violated. The executive director may modify or waive the net worth requirement if he determines that it is reasonable or necessary to do so and that the financial interests of the authority are adequately protected.

13VAC10-40-100. Maximum gross income.

A. As provided in 13VAC10-40-50 A ~~6~~ 5, the gross income of ~~the~~ an applicant ~~or applicants~~ for an authority mortgage loan may not exceed the applicable income limitation imposed by the U.S. Department of the Treasury. Because the income limits of the authority imposed by this section apply to all loans to which such federal limits apply and are in all cases below such federal limits, the requirements of 13VAC10-40-50 A ~~6~~ 5 are automatically met if ~~the~~ an applicant's ~~or applicants'~~ gross income does not exceed the applicable limits set forth in this section.

~~For the purposes hereof, the term "gross income" means the combined annualized gross income of all persons residing or intending to reside in a dwelling unit, from whatever source derived and before taxes or withholdings. For the purpose of this definition, annualized gross income means gross monthly income multiplied by 12. "Gross monthly income" is, in turn, the sum of monthly gross pay plus any additional income from overtime, part-time employment, bonuses, dividends, interest, royalties, pensions, Veterans Administration compensation, net rental income plus other income (such as alimony, child support, public assistance, sick pay, social security benefits, unemployment compensation, income received from trusts, and income received from business activities or investments)~~ B. Gross income is calculated by projecting gross income forward for the 12-month period beginning on the date of loan application. Typically, income such as bonuses, overtime, and commissions will be averaged for the most recent 12-month period. If information is unavailable for this period, the originating lender may average the past year and year-to-date bonuses, overtime, and commissions. This average multiplied by 12 will be added to current base salary to determine gross income. All such earnings must be included in gross income unless the employer documents that such earnings will not be continued. The following are included in gross income: base salary, overtime, part-time employment, bonuses, dividends, interest, royalties, pensions, Veterans Administration compensation, net rental income, alimony, child support, public assistance, sick pay, social security benefits, unemployment compensation, income from trusts, and income from business activities or investments.

C. The executive director shall, from time to time, establish the applicable maximum gross incomes. Each such maximum gross income shall be expressed as a percentage (which may be based on the number of persons expected to occupy the dwelling upon financing of the mortgage loan) of the applicable median family income ~~(as defined in Section 143(f)(4) of the Internal Revenue Code of 1986, as amended and referred to herein as the "median family income")~~ or as a dollar amount, which percentage or dollar amount may vary by loan program and geographic region as determined by the executive director, after taking into consideration such factors as he deems appropriate, including, without limitation, the following factors:

1. The current and anticipated financial resources available to the authority to make mortgage loans;

2. The current and anticipated financial resources available to potential applicants from sources other than the authority to finance mortgage loans;

3. The current and anticipated demand for mortgage loans;

4. The prevailing mortgage loan terms available to potential applicants; and

5. The current and anticipated need for targeted or subsidized lending in each region based upon financial conditions and the housing market in such region.

D. The executive director shall apply the ~~foregoing~~ factors in subsection C of this section to establish the maximum gross incomes that enable the authority to effectively and efficiently allocate its current and anticipated financial resources so as to best meet the current and future housing needs of ~~the citizens throughout the Commonwealth~~ low and moderate income Virginians.

The authority shall from time to time inform its originating ~~agents and servicing agents~~ lenders by written notification ~~thereto~~ of the ~~foregoing~~ maximum gross incomes under this section expressed in dollar amounts for each area of the state, as established by the executive director, and the number of persons to occupy the dwelling, if applicable. Any changes to the dollar amounts of such maximum gross incomes shall be effective as of such date as the executive director shall determine (subject to any exceptions for ~~pending loan reservations or applications~~ locked loans as the executive director may determine), and ~~authority is reserved to~~ the executive director ~~to~~ may implement any such changes on such date ~~or dates~~ as he shall deem necessary or appropriate to best accomplish the purposes of the program.

13VAC10-40-110. Calculation of maximum loan amount.

~~Single family detached residence, townhouse (fee simple ownership) and approved condominium Maximum~~ A maximum of 100% ~~(or,~~ or in the case of an FHA, VA, Rural Development, Fannie Mae, or Freddie Mac loan or a loan with private mortgage insurance, such other percentage as may be permitted by FHA, VA, Rural Development, Fannie Mae, Freddie Mac, or the private mortgage insurance ~~provider)~~ provider of the lesser of the sales price or appraised value~~, except as may otherwise be approved by the executive director; provided, however,~~. However, the executive director may establish ~~lower~~ other percentages if the executive director determines that ~~lower~~ other percentages are necessary to protect the authority's financial interests or to enable the authority to effectively and efficiently allocate its current and anticipated financial resources so as to best meet the current and future housing needs of the citizens throughout the Commonwealth.

In the case of an FHA, VA, or Rural Development loan, the FHA, VA, or Rural Development insurance fees or guarantee fees charged in connection with such loan ~~(and, if an FHA loan, the FHA permitted closing costs as well)~~, and other costs as allowed by the applicable insurer or guarantor, may be included in the calculation of the maximum loan amount in accordance with applicable FHA, VA or Rural Development requirements~~; provided, however, that~~. However, in no event shall this revised maximum loan amount, which includes such fees and closing costs, be permitted to exceed the authority's maximum allowable sales price limits set forth ~~herein~~ in this chapter.

13VAC10-40-120. Mortgage insurance requirements.

A. Unless the loan is an FHA, VA, or Rural Development loan, ~~the borrower or~~ all borrowers are required to purchase at time of loan closing ~~full~~ private mortgage insurance ~~(in an amount equal to the percentage of the loan that exceeds 80% of the lesser or sales price or appraised value of the property or such higher percentage as the executive director may determine is necessary to protect the authority's financial interests) on each loan the amount of which exceeds 80% of the lesser of sales price or appraised value of the property to be financed~~ in such amount as required by the applicable investor or such other amount as required by the executive director. Such insurance shall be issued by a company acceptable to the authority. The originating ~~agent~~ lender is required to escrow for annual payment of mortgage insurance, unless an alternative payment plan is approved by the authority. If the authority requires FHA, VA, or Rural Development insurance or guarantee, the loan will ~~either, at the election of the authority, (a) be closed in the authority's name in accordance with the procedures and requirements herein or (b)~~ be closed in the originating ~~agent's~~ lender's name and purchased by the authority once the FHA Certificate of Insurance, VA Guaranty, or Rural Development Guarantee has been obtained ~~or subject to the condition that such FHA Certificate of Insurance, VA Guaranty or Rural Development Guarantee be obtained. In the event that the authority purchases an FHA, VA or Rural Development loan, the originating agent must enter into a purchase and sale agreement on such form as shall be provided by the authority~~. For assumptions of conventional loans (i.e., loans other than FHA, VA, or Rural Development loans), ~~full~~ private mortgage insurance as described ~~above~~ in this subsection is required unless waived by the authority.

B. The executive director may waive the requirements for private mortgage insurance in ~~the preceding paragraph~~ subsection A of this section for a loan having a principal amount in excess of 80% of the lesser of sales price or appraised value of the property to be financed if ~~the applicant satisfies the criteria set forth in subdivisions 11 through 17 of 13VAC10-40-230 or if~~ the executive director otherwise determines that the financial integrity of the program is protected by the financial strength of ~~the~~ an applicant ~~or applicants~~ or the terms of the financing.

C. If the executive director determines it to be necessary to protect the authority's financial interests, the executive director may require that the company issuing such private mortgage insurance have a Moody's Investors Service Insurance Financial Strength rating not lower than Aa3 or a Standard & Poor's Ratings Services Financial Strength rating not lower than AA-.

13VAC10-40-130. Underwriting.

A. In general, to be eligible for authority financing, an applicant ~~or applicants~~ must satisfy the following underwriting criteria, which demonstrate the willingness and ability to repay the mortgage debt and adequately maintain the financed property.

1. ~~The~~ An applicant ~~or applicants~~ must document the receipt of a stable current income [~~which~~ that] indicates that the applicant ~~or applicants~~ will receive future income ~~which~~ that is sufficient to enable the timely repayment of the mortgage loan as well as other existing obligations and living expenses.

2. ~~The~~ Each applicant ~~or, in the case of multiple applicants, the applicants individually and collectively~~ must possess a credit history ~~which~~ that reflects the ability to successfully meet financial obligations and a willingness to repay obligations in accordance with established credit repayment terms.

3. ~~An applicant having a foreclosure instituted by the authority on his property financed by an authority mortgage loan will not be eligible for a mortgage loan hereunder. The authority will consider previous foreclosures (other than on authority financed loans) on an exception basis based upon circumstances surrounding the cause of the foreclosure, length of time since the foreclosure, the applicant's subsequent credit history and overall financial stability. Under no circumstances will an applicant be considered for an authority loan within three years from the date of the foreclosure.~~ Applicants with prior significant mortgage events (foreclosure, deed in lieu, or short sale) must meet the applicable insurer, guarantor, or investor requirements in addition to any additional requirements imposed by the executive director. The authority has complete discretion to decline to finance a loan when a previous foreclosure is involved.

4. The ~~applicant or~~ applicants must document that sufficient funds will be available for required down payment and closing costs. ~~a. The terms and sources of any loan to be used as a source for down payment or closing costs must be reviewed and approved in advance of loan approval by the authority. b.~~ Sweat equity, the imputed value of services performed by an eligible borrower or members of ~~his~~ the borrower's family ~~(brothers and sisters~~ (siblings, spouse, ancestors, and lineal descendants) in constructing or completing the residence, generally is not an acceptable source of funds for [down payment ~~downpayment~~] and closing costs. Any sweat equity allowance must be approved by the authority prior to loan approval.

5. Proposed monthly housing expenses compared to current monthly housing expenses will be reviewed. If there is a substantial increase in such expenses, ~~the~~ an applicant ~~or applicants~~ must demonstrate his ability to pay the additional expenses.

6. All applicants are encouraged to attend a home ownership educational program to be better prepared to deal with the home buying process and the responsibilities related to homeownership. The authority may require all applicants applying for certain authority loan programs to complete an authority approved homeownership education program prior to loan approval.

B. In addition to the requirements set forth in subsection A of this section, ~~the following requirements must be met in order to satisfy the authority's underwriting requirements for conventional loans~~ to be eligible for authority financing, an applicant must satisfy the specific underwriting criteria of the insurer, guarantor, or investor with respect to the applicable authority loan program. However, additional or more stringent requirements may be imposed (i) by private mortgage insurance companies with respect to those loans on which private mortgage insurance is required~~; (ii) on loans as described in the last paragraph of 13VAC10-40-120; or (iii) on loans that may be sold by the authority to an investor (including, without limitation, Fannie Mae, Freddie Mac, and Ginnie Mae)~~ or (ii) by the executive director, in which ~~case~~ cases such additional or more stringent requirements ~~of the investor~~ will apply.

C. The authority reserves the right to obtain an independent appraisal in order to establish the fair market value of the property and to determine whether the dwelling is eligible for the mortgage loan requested.

D. The FHA mortgage insurance premium fee, the VA funding fee, and the Rural Development guarantee fee can be included in the loan amount provided the final loan amount does not exceed the authority's maximum allowable sales price.

~~1. The following rules apply to the authority's employment and income requirement.~~

~~a. Employment for the preceding two-year period must be documented. Education or training for employment during this two-year period shall be considered in satisfaction of this requirement if such education or training is related to an applicant's current line of work and adequate future income can be anticipated because such education and training will expand the applicant's job opportunities. The applicant must be employed a minimum of six months with present employer. An exception to the six-month requirement can be granted by the authority if it can be determined that the type of work is similar to previous employment and previous employment was of a stable nature.~~

~~b. Note: Under the tax code, the residence may not be expected to be used in trade or business. (See 13VAC10-40-50 C.) Any self-employed applicant must have a~~

minimum of two years of self-employment with the same company and in the same line of work. In addition, the following information is required at the time of application:

(1) Federal income tax returns for the two most recent tax years.

(2) Balance sheets and profit and loss statements prepared by an independent public accountant.

In determining the income for a self-employed applicant, income will be averaged for the two-year period.

c. The following rules apply to income derived from sources other than primary employment.

(1) When considering alimony and child support. A copy of the legal document and sufficient proof must be submitted to the authority verifying that alimony and child support are court-ordered and are being received. Child support payments for children 15 years or older are not accepted as income in qualifying an applicant or applicants for a loan.

(2) When considering social security and other retirement benefits. Social Security Form No. SSA-2458 must be submitted to verify that applicant is receiving social security benefits. Retirement benefits must be verified by receipt or retirement schedules. VA disability benefits must be verified by the VA. Educational benefits and social security benefits for dependents 15 years or older are not accepted as income in qualifying an applicant or applicants for a loan.

(3) All part-time employment must be continuous for a minimum of 24 months, except that the authority may consider part-time employment that is continuous for more than 12 months but less than 24 months if such part-time employment is of a stable nature and is likely to continue after closing of the mortgage loan.

(4) Overtime earnings must be guaranteed by the employer or verified for a minimum of two years. Bonus and commissions must be reasonably predictable and stable and the applicant's employer must submit evidence that they have been paid on a regular basis and can be expected to be paid in the future.

2. The following rules apply to each applicant's credit:

a. The authority requires that an applicant's previous credit experience be satisfactory. Poor credit references without an acceptable explanation will cause a loan to be rejected. Satisfactory credit references and history are considered to be important requirements in order to obtain an authority loan. The executive director may impose a minimum credit score requirement if the executive director determines that such a requirement is standard and customary in the single family mortgage loan industry and is necessary to protect the authority's financial interests.

b. An applicant will not be considered for a loan if the applicant has been adjudged bankrupt within the past two years. If longer than two years, the applicant must submit a written explanation giving details surrounding the bankruptcy. The authority has complete discretion to decline a loan when a bankruptcy is involved.

c. An applicant is required to submit a written explanation for all judgments and collections. In most cases, judgments and collections must be paid before an applicant will be considered for an authority loan.

3. The authority reserves the right to obtain an independent appraisal in order to establish the fair market value of the property and to determine whether the dwelling is eligible for the mortgage loan requested.

4. The applicant or applicants satisfy the authority's minimum income requirement for financing if the monthly principal and interest (at the rate determined by the authority), tax, insurance ("PITI") and other additional monthly fees such as condominium association fees (excluding unit utility charges), townhouse assessments, etc. do not exceed 32% of monthly gross income and if the monthly PITI plus outstanding monthly debt payments with more than 10 months duration (and payments on debts lasting less than 10 months, if making such payments will adversely affect the applicant's or applicants' ability to make mortgage loan payments in the months following loan closing) do not exceed 40% of monthly gross income (see Exhibit B). However, with respect to those mortgage loans on which private mortgage insurance is required, the private mortgage insurance company may impose more stringent requirements. If either of the percentages set forth are exceeded, compensating factors may be used by the authority, in its sole discretion, to approve the mortgage loan.

5. Funds necessary to pay the downpayment and closing costs must be deposited at the time of loan application. The authority does not permit an applicant to borrow funds for this purpose unless approved in advance by the authority. If the funds are being held in an escrow account by the real estate broker, builder or closing attorney, the source of the funds must be verified. A verification of deposit from the parties other than financial institutions authorized to handle deposited funds is not acceptable.

6. The applicant may receive a gift from only a relative, employer or nonprofit entity not involved in the transfer or financing of the property. The individual(s) making the gift must provide a letter to the authority confirming that the transfer of funds is a gift with no obligation on the part of an applicant to repay the funds at any time. The party making the gift must submit proof that the funds are

~~available. The executive director may approve gifts from other sources provided the executive director determines that such transfer of funds to the applicant is not subject to repayment by the applicant and is not made in consideration of any past or future obligation of the applicant or in consideration of any terms of the property transfer or mortgage loan transaction.~~

~~7. Seller contributions for settlement or financing costs (including closing costs, discount points and upfront mortgage insurance premiums) may not exceed the lesser of 6.0% of the sales price or the amount permitted by the applicable mortgage insurer guidelines.~~

~~C. The following rules are applicable to FHA loans only.~~

~~1. The authority will normally accept FHA underwriting requirements and property standards for FHA loans. However, the applicant or applicants must satisfy the underwriting criteria set forth in subsection A of this section and most of the authority's basic eligibility requirements including those described in 13VAC10-40-30 through 13VAC10-40-100 hereof remain in effect due to treasury restrictions or authority policy. In addition, the executive director may impose one or more of the requirements of subsection B of this section to FHA loans on the same or less stringent basis as they apply to the authority's conventional loans if the executive director determines that such requirements are necessary to protect its financial interests.~~

~~2. The applicant's or applicants' mortgage insurance premium fee may be included in the FHA acquisition cost and may be financed provided that the final loan amount does not exceed the authority's maximum allowable sales price. In addition, in the case of a condominium, such fee may not be paid in full in advance but instead is payable in annual installments.~~

~~3. The FHA allowable closing fees may be included in the FHA acquisition cost and may be financed provided the final loan amount does not exceed the authority's maximum allowable sales price.~~

~~4. FHA appraisals are acceptable. VA certificates of reasonable value (CRV's) are acceptable if acceptable to FHA.~~

~~D. The following rules are applicable to VA loans only.~~

~~1. The authority will normally accept VA underwriting requirements and property guidelines for VA loans. However, the applicant or applicants must satisfy the underwriting criteria set forth in subsection A of this section and most of the authority's basic eligibility requirements (including those described in 13VAC10-40-30 through 13VAC10-40-100) remain in effect due to treasury restrictions or authority policy. In addition, the executive director may impose one or more of the requirements of subsection B of this section to VA loans on the same or less stringent basis as they apply to the authority's conventional loans if the executive director determines that such requirements are necessary to protect its financial interests.~~

~~2. The funding fee can be included in loan amount provided the final loan amount does not exceed the authority's maximum allowable sales price.~~

~~3. VA certificates of reasonable value (CRV's) are acceptable in lieu of an appraisal.~~

~~E. The following rules are applicable to Rural Development loans only.~~

~~1. The authority will normally accept Rural Development underwriting requirements and property standards for Rural Development loans. However, the applicant or applicants must satisfy the underwriting criteria set forth in subsection A of this section and most of the authority's basic eligibility requirements including those described in 13VAC10-40-30 through 13VAC10-40-100 remain in effect due to treasury restrictions or authority policy. In addition, the executive director may impose one or more of the requirements of subsection B of this section to Rural Development loans on the same or less stringent basis as they apply to the authority's conventional loans if the executive director determines that such requirements are necessary to protect its financial interests.~~

~~2. The Rural Development guarantee fee can be included in loan amount provided the final loan amount does not exceed the authority's maximum allowable sales price.~~

~~F. With respect to FHA, VA, RD and conventional loans, the authority permits the deposit of a sum of money (the "buydown funds") by a party (the "provider") with an escrow agent, a portion of which funds are to be paid to the authority each month in order to reduce the amount of the borrower's or borrowers' monthly payment during a certain period of time. Such arrangement is governed by an escrow agreement for buydown mortgage loans (see Exhibit V) executed at closing (see 13VAC10-40-180 for additional information). The escrow agent will be required to sign a certification (Exhibit X) in order to satisfy certain insurer or guarantor requirements.~~ E. For the purposes of underwriting ~~buydown~~ buy-down mortgage loans, the reduced monthly payment amount may be taken into account based on the applicable insurer ~~or~~, guarantor, or investor guidelines then in effect ~~(see also subsection C, D or E of this section, as applicable)~~.

~~G. Unlike the program described in subsection E of this section which permits a direct buydown of the borrower's or borrowers' monthly payment, the authority also from time to time permits the buydown of the interest rate on a conventional, FHA or VA mortgage loan for a specified period of time.~~

13VAC10-40-140. Loan assumptions.

A. ~~VHDA~~ The authority may from time to time, in its discretion, permit assumptions of all or some of its single family mortgage loans, subject to satisfaction of (i) the ~~applicable~~ requirements ~~in this section~~ of the insurer, guarantor, or investor with respect to the applicable authority loan program and (ii) the requirements of the tax code if the mortgage loan was funded with the proceeds of tax-exempt bonds; provided, however, that assumptions shall be permitted when required by the mortgage insurer ~~or~~, guarantor, or investor rules or applicable law. ~~if the applicable requirements in this section are met. For all loans closed prior to January 1, 1991, except FHA loans which were closed during calendar year 1990, the maximum gross income for the person or persons assuming a loan shall be 100% of the applicable median family income. For such FHA loans closed during 1990, if assumed by a household of three or more persons, the maximum gross income shall be 115% of the applicable median family income (140% for a residence in a targeted area) and if assumed by a household of fewer than three persons, the maximum gross income shall be 100% of the applicable median family income (120% for a residence in a targeted area). For all loans closed after January 1, 1991, the maximum gross income for the person or persons assuming loans shall be the highest percentage, as then in effect under 13VAC10-40-100 A, of applicable median family income for the number or persons to occupy the dwelling upon assumption of the mortgage loan, unless otherwise provided in the deed of trust. The requirements for each of the two different categories of mortgage loans listed below (and the subcategories within each) are as follows:~~

~~1. The following rules apply to assumptions of conventional loans, if permitted by the authority.~~

~~a. For assumptions of conventional loans financed by the proceeds of bonds issued on or after December 17, 1981, the requirements of the following sections hereof must be met:~~

~~(1) Maximum gross income requirement in 13VAC10-40-140 A~~

~~(2) 13VAC10-40-50 C (Principal residence requirement)~~

~~(3) 13VAC10-40-130 (Authority underwriting requirements)~~

~~(4) 13VAC10-40-50 B (Three-year requirement)~~

~~(5) 13VAC10-40-60 B (Acquisition cost requirements)~~

~~(6) 13VAC10-40-120 (Mortgage insurance requirements).~~

~~b. For assumptions of conventional loans financed by the proceeds of bonds issued prior to December 17, 1981, the requirements of the following sections hereof must be met:~~

~~(1) Maximum gross income requirement in 13VAC10-40-140 A~~

~~(2) 13VAC10-40-50 C (Principal residence requirements)~~

~~(3) 13VAC10-40-130 (Authority underwriting requirements)~~

~~(4) 13VAC10-40-120 (Mortgage insurance requirements).~~

~~2. The following rules apply to assumptions of FHA, VA or Rural Development loans, if permitted by the authority.~~

~~a. For assumptions of FHA, VA or Rural Development loans financed by the proceeds of bonds issued on or after December 17, 1981, the following conditions, if applicable, must be met:~~

~~(1) Maximum gross income requirement in this 13VAC10-40-140 A~~

~~(2) 13VAC10-40-50 C (Principal residence requirement)~~

~~(3) 13VAC10-40-50 B (Three-year requirement)~~

~~(4) 13VAC10-40-60 B (Acquisition cost requirements).~~

~~In addition, all applicable FHA, VA or Rural Development underwriting requirements, if any, must be met.~~

~~b. For assumptions of FHA, VA or Rural Development loans financed by the proceeds of bonds issued prior to December 17, 1981, only the applicable FHA, VA or Rural Development underwriting requirements, if any, must be met.~~

B. If the authority ~~will permit~~ permits an assumption, the authority will determine whether or not the applicable requirements ~~referenced above~~ in subsection A of this section for assumption of the loan have been met and will advise the originating ~~agent or servicing agent~~ lender of such determination in writing. The authority will further advise the originating ~~agent or servicing agent~~ lender of all other requirements necessary to complete the assumption process. Such requirements may include [~~but are not limited to~~] the submission of satisfactory evidence of hazard insurance coverage on the property, approval of the deed of assumption, satisfactory evidence of mortgage insurance or mortgage guaranty ~~including, if applicable, pool insurance~~, submission of an escrow transfer letter, and execution of ~~a Recapture Requirement Notice (VHDA Doc. R-1)~~ the programs disclosure and borrower affidavit (Exhibit E2) containing a recapture tax notice.

13VAC10-40-150. ~~Leasing, loan~~ Loan term~~,~~ and owner occupancy.

~~A. The owner may not lease the property without first contacting the authority.~~

~~B. Loan~~ A. No loan terms may ~~not~~ exceed 30 years.

~~C.~~ B. No loan will be made unless the residence is to be occupied by the owner as the owner's principal residence.

13VAC10-40-160. ~~Reservations/fees~~ Loan lock-in and fees.

A. ~~The authority currently reserves funds for each mortgage loan on a first come, first serve basis. Reservations are made by specific originating agents or field originators with respect to specific applicants and properties. No substitutions are permitted. Similarly, locked in interest rates are also nontransferable. However, if the applicant can document circumstances beyond the applicant's control constituting good cause, the executive director may permit such substitution and transfer. Funds will not be reserved longer than 60 days unless the originating agent requests and receives an additional one time extension prior to the 60 day deadline; provided, however, the foregoing time periods may be shortened by the executive director as he deems necessary if the mortgage loan is to be sold by the authority to an investor (including, without limitation, Fannie Mae, Freddie Mac, and Ginnie Mae). Locked in interest rates on all loans, including those on which there may be a VA Guaranty, cannot be reduced under any circumstances~~ Authority loans may be locked-in by originating lenders for specific borrowers and properties. The interest rate is locked-in after loan application and after the originating lender has determined that the borrower meets the eligibility requirements and guidelines for the loan program. No substitutions of borrower, property, or originating lender are permitted. A change in loan program may require the loan to be [~~relocked~~ relocked-in] at different terms.

B. ~~The applicant or applicants, including an applicant or applicants for a loan to be guaranteed by VA, may request a second reservation if the first has expired or has been cancelled. If the second reservation is made within 12 months of the date of the original reservation, the interest rate will be the greater of (i) the locked-in rate or (ii) the current rate offered by the authority at the time of the second reservation. However, if the applicant can document circumstances beyond the applicant's control constituting good cause, the executive director may waive the requirement in the preceding sentence~~ Loans may be locked-in at an interest rate for different periods of time. The loan must close by the lock-in expiration date.

C. ~~The originating agent or field originator shall collect a nonrefundable reservation fee in such amount and according to such procedures as the authority may require from time to time. Under no circumstances is this fee refundable. A second reservation fee must be collected for a second reservation. No substitutions of applicants or properties are permitted~~ The originating lender may request extensions to the rate [~~lock~~ lock-in] period, up to a maximum period of time. [~~Lock~~ Lock-in] extension requests must be submitted on or before the [~~lock~~ lock-in] expiration date. Each extension may be subject to a fee. This cost will be deducted from the net price of the loan. Extensions will not be processed on expired [~~locks~~ lock-ins].

D. ~~The following other fees shall be collected.~~

~~1. In connection with the origination and closing of the loan, the originating agent shall collect at closing or, at the authority's option, simultaneously with the acceptance of the authority's commitment, an amount equal to 1.0% of the loan amount (please note that for FHA loans the loan amount for the purpose of this computation is the base loan amount only); provided, however, that the executive director may require the payment of an additional fee not in excess of 1.0% of the loan amount in the case of a step loan (i.e., a loan on which the initial interest rate is to be increased to a new interest rate after a fixed period of time). If the loan does not close, then the origination fee shall be waived.~~

~~2. The originating agent shall collect at the time of closing an amount equal to 1.0% of the loan amount.~~

~~If the executive director determines that the financial integrity of the program is protected by an adjustment to the rate of interest charged to the applicant or applicants or otherwise, the authority may provide the applicant or applicants with the option of an alternative fee requirement~~ Unless otherwise stated in specific program guidelines, the originating lender may not earn compensation in excess of such amount set forth in the origination guide, including any points charged and the service release premium, on each loan. Any excess compensation must be applied as a lender credit to the borrower. In addition, the originating lender may collect fees for reimbursement of costs incurred, such as credit reports, appraisals, tax service fees, or flood certification fees, as applicable.

E. Unless otherwise stated in specific program guidelines, a service release premium will be paid to the originating lender by the authority at the time of purchase in such amount set forth in the origination guide. The premium will be for both first and second mortgages if applicable. This will be included in the net price of the loan when purchased by the authority.

F. For all loan programs, originating lenders are allowed to collect customary miscellaneous fees (i.e., underwriting, document review fees) that have been properly disclosed to the applicant at the time of loan application.

13VAC10-40-170. ~~Commitment~~ Loan decision.

A. ~~Upon approval of the applicant or applicants, the authority will send a mortgage loan commitment to the borrower or borrowers in care of the originating agent. The originating agent shall ask the borrower or borrowers to indicate acceptance of the mortgage loan commitment by signing and returning it to the originating agent prior to~~

~~settlement~~ Nondelegated lenders or delegated lenders submitting loans for programs that are not eligible for the delegated process [,] will submit loans to the authority for approval. Upon approval of an applicant, the authority will send a loan approval to the originating lender. If a loan is denied, the authority will send a notification to the originating lender.

~~A commitment must be issued in writing by an authorized officer of the authority and signed by the applicant or applicants before a loan may be closed. The term of a commitment may be extended in certain cases upon written request by the applicant or applicants and approved by the authority. If an additional commitment is issued to an applicant or applicants, the interest rate may be higher than the rate offered in the original commitment and additional fees may be charged. Such new rate and the availability of funds therefor shall in all cases be determined by the authority in its discretion.~~

B. ~~If the application fails to meet any of the standards, criteria and requirements herein, a loan rejection letter will be issued by the authority (see Exhibit L). In order to have the application reconsidered, the applicant or applicants must resubmit the application within 30 days after loan rejection. If the application is so resubmitted, the credit documentation cannot be more than 90 days old and the appraisal not more than six months old.~~ Delegated lenders will approve the loan without prior review by the authority.

C. For mortgage loans to be made by the authority directly to borrowers in underserved markets, the authority will issue the loan approval or loan denial directly to the loan applicant.

13VAC10-40-180. Buy-down ~~points~~ mortgage loans.

~~With respect to checks for buy down points under both the monthly payment buydown program described in 13VAC10-40-130 F above and the interest rate buydown program described in 13VAC10-40-130 G). A certified or cashier's check made payable to the authority is to be provided at loan closing for buy down points, if any. Under the tax code, the original proceeds of a bond issue may not exceed the amount necessary for the "governmental purpose" thereof by more than 5.0%. If buy down points are paid out of mortgage loan proceeds (which are financed by bonds), then this federal regulation is violated because bond proceeds have in effect been used to pay debt service rather than for the proper "governmental purpose" of making mortgage loans. Therefore, it is required that buy down fees be paid from the seller's own funds and not be deducted from loan proceeds. Because of this requirement, buy down funds may not appear as a deduction from the seller's proceeds on the HUD-1 Settlement Statement~~ The authority may permit buy-down mortgage loan options. Such buy-down mortgage loan options must meet all applicable insurer, guarantor, or investor requirements.

13VAC10-40-190. Property guidelines.

~~A.~~ For each application the authority must make the determination that the property will constitute adequate security for the loan. That determination ~~shall in turn~~ may be based ~~solely~~ in whole or in part upon a real estate appraisal's determination of the value and condition of the property, unless an appraisal is not required based upon the applicable insurer, guarantor, or investor program requirements. Such appraisal must be performed by an appraiser licensed in the Commonwealth of Virginia.

When the residence is located in an area experiencing a decline in property values as determined by the appraiser or the executive director based upon objective quantitative data, the executive director may establish additional requirements, including~~, without limitation,~~ lower loan to value ratios, for such loan as determined necessary by the executive director to protect the financial interests of the authority.

All properties must be structurally sound and in adequate condition to preserve the continued marketability of the property and to protect the health and safety of the occupants. Eligible properties must possess features ~~which~~ that are acceptable to typical purchasers in the subject market area and provide adequate amenities. Eligible properties must meet ~~Fannie Mae and Freddie Mac property guidelines unless otherwise approved by the authority~~ the property guidelines of the applicable insurer, guarantor, or investor.

~~All properties must be structurally sound and in adequate condition to preserve the continued marketability of the property and to protect the health and safety of the occupants. Eligible properties must possess features that are acceptable to typical purchasers in the subject market area and provide adequate amenities. Eligible properties must meet FNMA and FHLMC property guidelines unless otherwise approved by the authority.~~

In addition, manufactured housing, both new construction and certain existing, may be financed only if the loan ~~is insured 100% by FHA (see subsection C of this section).~~ meets the requirements of the applicable insurer, guarantor, or investor. Manufactured housing must also meet federal manufactured home construction and safety standards administered by the U.S. Department of Housing and Urban Development; be permanently attached to the land and anchored per manufacturer specifications or state and local building codes; and have the wheels, axles, and trailer hitches removed. In addition, the property must be assessed and taxed as real estate, and there must be evidence that the title has been surrendered to DMV and all personal property liens released. The authority may also impose other property requirements and offer other financing terms for manufactured housing, provided that the executive director determines that such property requirements and financing terms adequately protect the financial integrity of the program.

B. The following rules apply to conventional loans.

1. The following requirements apply to both new construction and existing housing to be financed by a conventional loan: (i) all property must be located on a state maintained road; provided, however, that the authority may, on a case by case basis, approve financing of property located on a private road acceptable to the authority if the right to use such private road is granted to the owner of the residence pursuant to a recorded right of way agreement providing for the use of such private road and a recorded maintenance agreement provides for the maintenance of such private road on terms and conditions acceptable to the authority (any other easements or rights of way to state maintained roads are not acceptable as access to properties); (ii) any easements, covenants or restrictions which will adversely affect the marketability of the property, such as high tension power lines, drainage or other utility easements will be considered on a case by case basis to determine whether such easements, covenants or restrictions will be acceptable to the authority; (iii) property with available water and sewer hookups must utilize them; and (iv) property without available water and sewer hookups may have their own well and septic system; provided that joint ownership of a well and septic system will be considered on a case by case basis to determine whether such ownership is acceptable to the authority, provided further that cisterns will be considered on a case by case basis to determine whether the cistern will be adequate to serve the property.

2. New construction financed by a conventional loan must also meet Virginia Statewide Building Code and local code.

C. The following rules apply to FHA, VA or Rural Development loans.

1. Both new construction and existing housing financed by an FHA, VA or Rural Development loan must meet all applicable requirements imposed by FHA, VA or Rural Development.

2. Manufactured housing being financed by FHA loans must also meet federal manufactured home construction and safety standards, satisfy all FHA insurance requirements, be on a permanent foundation to be enclosed by a perimeter masonry curtain wall conforming to standards of the Virginia Statewide Building Code, be permanently affixed to the site owned by the borrower or borrowers and be insured 100% by FHA under its section 203B program. In addition, the property must be classified and taxed as real estate and no personal property may be financed.

13VAC10-40-200. Substantially rehabilitated. (Repealed.)

For the purpose of qualifying as substantially rehabilitated housing under the authority's maximum sales price limitations, the housing unit must meet the following definitions:

1. Substantially rehabilitated means improved to a condition which meets the authority's underwriting/property standard requirements from a condition requiring more than routine or minor repairs or improvements to meet such requirements. The term includes repairs or improvements varying in degree from gutting and extensive reconstruction to cosmetic improvements which are coupled with the cure of a substantial accumulation of deferred maintenance, but does not mean cosmetic improvements alone.

2. For these purposes a substantially rehabilitated housing unit means a dwelling unit which has been substantially rehabilitated and which is being offered for sale and occupancy for the first time since such rehabilitation. The value of the rehabilitation must equal at least 25% of the total value of the rehabilitated housing unit.

3. The authority's staff will inspect each house submitted as substantially rehabilitated to ensure compliance with our underwriting property standards. An appraisal is to be submitted after the authority's inspection and is to list the improvements and estimate their value.

4. The authority will only approve rehabilitation loans to an eligible borrower or borrowers who will be the first resident of the residence after the completion of the rehabilitation. As a result of the tax code, the proceeds of the mortgage loan cannot be used to refinance an existing mortgage, as explained in 13VAC10-40-50 D. The authority will approve loans to cover the purchase of a residence, including the rehabilitation:

a. Where the eligible borrower or borrowers are acquiring a residence from a builder or other seller who has performed a substantial rehabilitation of the residence; and

b. Where the eligible borrower or borrowers are acquiring an unrehabilitated residence from the seller and the eligible borrower or borrowers contract with others to perform a substantial rehabilitation or performs the rehabilitation work himself prior to occupancy.

13VAC10-40-210. Condominium requirements.

A. For conventional loans, the originating ~~agent~~ lender must provide evidence that the condominium meets the eligibility requirements of either Fannie Mae or Freddie Mac, as determined by the loan program. The originating ~~agent~~ lender must submit evidence ~~at the time the borrower's or borrowers' application is submitted to the authority for approval. The executive director may require additional evidence of marketability of the condominium unit, such as a market study prepared by qualified professional, if the executive director determines that such additional evidence is necessary~~

~~to protect the financial interests of the authority~~ of eligibility to the authority.

B. For FHA, VA, or Rural Development loans, the authority will accept a loan to finance a condominium if the condominium is approved by FHA, in the case of an FHA loan [~~,~~ ;] by VA, in the case of a VA loan[~~,~~ ;] or ~~be~~ by Rural Development, in the case of a Rural Development loan.

C. The executive director may impose additional condominium requirements if necessary to protect the financial interests of the authority. The executive director may waive any requirements in subsections A and B of this section if he determines that any additional risk as a result of such waiver is adequately compensated or otherwise covered by the terms of the mortgage loan or the financial strength or credit of the applicant ~~or applicants~~.

13VAC10-40-220. ~~FHA plus~~ Subordinate financing program.

A. ~~Notwithstanding anything to the contrary herein, the~~ The authority may make loans secured by second deed of trust liens ~~("second loans")~~ (second mortgage loans) to provide [~~downpayment~~ down payment] and closing cost assistance to ~~an~~ eligible ~~borrower or~~ borrowers who are obtaining ~~FHA~~ authority loans secured by first deed of trust liens (first mortgage loans). Such first ~~deed of trust liens~~ mortgage loans must be financed by the authority; provided that the authority may, in its discretion, permit such first deeds of trust to be financed by other lenders, subject to such terms and conditions as the executive director shall determine to be necessary to protect the financial integrity of the ~~FHA plus~~ subordinate financing program. Second mortgage loans shall not be available to a borrower [~~or borrowers~~] if the ~~FHA~~ authority loan is being made under ~~the FHA buydown~~ a buy-down program ~~or is subject to a step adjustment in the interest rate thereon or is subject to a reduced interest rate due to the financial support of the authority~~.

B. The second mortgage loans shall not be insured by mortgage insurance; accordingly, the requirements of 13VAC10-40-120 regarding mortgage insurance shall not be applicable to the second mortgage loan.

C. The requirements of 13VAC10-40-110 regarding calculation of maximum loan amount shall not be applicable to the second mortgage loan. ~~In order to be eligible for a second loan, the borrower or borrowers must obtain an FHA loan for the maximum loan amount permitted by FHA.~~ The principal amount of the second mortgage loan shall not exceed ~~5.0% of the lesser of the sales price or appraised value, or such lesser percentage as may be determined by the executive director to protect the financial integrity of the FHA plus program~~ the amount of the [~~downpayment~~ down payment] plus closing costs, or such lesser amount as may be set forth in specific program guidelines.

In no event shall the combined ~~FHA~~ first mortgage loan and the second mortgage loan ~~amount~~ and all other liens exceed (i) the amount allowed by the guidelines of the applicable insurer, guarantor, or investor or (ii) the sum of the lesser of the sales price or appraised value plus closing costs and fees to be paid by a borrower ~~or (ii) the authority's maximum allowable sales price. The sum of all liens may not exceed 100% of the cost to acquire the property. The cost to acquire the property is the sales price plus allowable borrower paid closing costs, discount points and prepaid expenses~~.

Verified liquid funds ~~(funds other than gifts, loans or retirement accounts) in an amount not less than 1.0% of the sales price must be: (i)~~ may be required to be (i) contributed by the borrower toward the [~~downpayment~~ down payment]; (ii) contributed by the borrower ~~or borrowers towards~~ toward closing costs or prepaid items; ~~(ii)~~ or (iii) retained by the borrower ~~or borrowers~~ as cash reserves after closing~~; or (iii) contributed and retained by the borrower or borrowers for the purposes of clauses (i) and (ii), respectively~~. The ~~FHA insured~~ first mortgage loan when combined with the ~~FHA plus~~ second mortgage loan and any other liens may not result in cash back to the borrower.

D. If the authority is not making the ~~FHA~~ first mortgage loan ~~secured by the first deed of trust lien~~, the authority may require that, as a condition of financing the ~~FHA plus~~ second mortgage loan, the ~~FHA~~ first mortgage loan ~~secured by the first deed of trust lien~~ meet the authority's requirements applicable to ~~FHA loans~~ that first mortgage loan program. With respect to underwriting, more stringent requirements or criteria than those applicable to the ~~FHA~~ first mortgage loan may be imposed on the second mortgage loan if the executive director determines such more stringent requirements or criteria are necessary to protect the financial integrity of the ~~FHA plus~~ subordinate financing program.

E. The second mortgage loan ~~shall~~ may be assumable on the same terms and conditions as the ~~FHA~~ first mortgage loan.

F. ~~No origination fee or discount point shall be collected on the second loan; provided, however, that the authority may charge an origination fee and/or a discount point in an amount determined by the executive director to be necessary to compensate the authority for originating, processing, and closing the FHA plus loan, if the first deed of trust is to be financed by another lender.~~ The authority may charge a higher interest rate on a first mortgage loan that is accompanied by a subordinate financing program second mortgage loan in order to protect the authority's interests and the financial integrity of the subordinate financing program.

G. ~~Upon approval of the applicant or applicants, the authority will issue a mortgage loan commitment pursuant to~~ The same loan decision procedures described in 13VAC10-40-170 will be used for the subordinate financing. ~~The mortgage loan commitment will include the terms and conditions of the FHA loan and the second loan and will set~~

~~forth additional terms and conditions applicable to the second loan. Also enclosed in the commitment package will be other documents necessary to close the second loan.~~

13VAC10-40-230. ~~Flexible alternative mortgage~~ Mortgage loan programs funded by taxable bonds.

The executive director may establish ~~flexible alternative~~ mortgage loan programs funded by taxable bonds or other resources. 13VAC10-40-10 through 13VAC10-40-220 shall apply to such ~~flexible alternative~~ mortgage loan programs, with the following modifications:

1. The following requirements shall not apply: (i) ~~the new mortgage requirement; (ii) the requirements as to the use of the property in a trade or business; (iii) the requirements~~ the requirement as to ~~acquisition cost and~~ maximum allowable sales price of the property to be financed; ~~(iv)~~ (ii) the requirement that each applicant shall not have had a present ownership interest in his principal residence within the preceding three years (the first-time homebuyer or three-year requirement); ~~(v)~~ (iii) the net worth requirement; ~~(vi) the requirements for the payment by the seller of an amount equal to 1.0% of the loan in 13VAC10-40-160 D 2;~~ and ~~(vii)~~ (iv) the lot size restriction in 13VAC10-40-50 C 3.

2. The gross income of the ~~applicant or~~ applicants shall not exceed 120% of the applicable median family income without regard to household size, provided, however, that the authority may increase such percentage of applicable median family income, not to exceed 150%, if the executive director determines that it is necessary to provide financing in underserved areas identified by the executive director to persons with disabilities (i.e., physically or mentally disabled, as determined by the executive director on the basis of medical evidence from a licensed physician or other appropriate evidence satisfactory to the executive director), to applicants with a household size of two or more persons, or other similarly underserved individuals identified by the executive director.

3. At the time of closing, each applicant must occupy or intend to occupy within 60 days ~~(90 days~~ (or such longer amount of time as the executive director determines is reasonable in the case of new construction) the property to be financed as his principal residence.

4. The property to be financed must be one of the following types: (i) a single family residence (attached or detached); (ii) a unit in a condominium or PUD ~~which~~ that is approved for financing by Fannie Mae or Freddie Mac or satisfies the requirements for such financing, except that the executive director may waive any of such requirements if he determines that any additional risk as a result of such waiver is adequately compensated or otherwise covered by the terms of the mortgage loan or the financial strength or credit of the ~~applicant or~~ applicants; or (iii) a doublewide manufactured home permanently affixed to the land.

5. The land, residence, and all other improvements on the property to be financed must be expected to be used by the ~~borrower or~~ borrowers primarily for residential purposes.

~~6. Personal property which is related to the use and occupancy of the property as the principal residence of the borrower or borrowers and is customarily transferred with single family residences may be included in the real estate contract, transferred with the residence and financed by the loan; however, the value of such personal property shall not be considered in the appraised value.~~

~~7. The principal amount of the mortgage loan shall not exceed the limits established by Fannie Mae or Freddie Mac for single family residences.~~

~~8. The maximum loan amount shall be calculated as follows:~~

~~a. If the authority loan will be used to acquire the residence, the loan amount (plus all subordinate debt to be secured by the property after closing of the authority loan) may not exceed 100% of the lesser of appraised value or sales price; provided, however, the executive director may establish a lower percentage if the executive director determines that such lower percentage is necessary to protect the authority's financial interests or to enable the authority to effectively and efficiently allocate its current and anticipated financial resources so as to best meet the current and future housing needs of the citizens throughout the Commonwealth. In the case of loans to finance such acquisition, the executive director may approve additional subordinate financing if he determines that any additional risk as a result of such additional subordinate financing is adequately compensated or otherwise covered by the terms of the mortgage loan or the financial strength or credit of the applicant or applicants.~~

~~b. If the loan proceeds will not be used to finance the acquisition of the residence, the loan amount (plus all subordinate debt to be secured by the property after closing of the authority loan) may not exceed the lesser of the current appraised value of the property or the sum of (i) the payoff (if any) of the applicant's existing first mortgage loan; (ii) the payoff (if any) of applicant's or applicants' subordinate mortgage loans (provided such loans do not permit periodic advancement of loan proceeds) closed for not less than 12 months preceding the date of the closing of the authority loan and the payoff (if any) of applicant's or applicants' home equity line of credit loan (i.e., loan that permits periodic advancement of proceeds) with no more than $2,000 in advances within the 12 months preceding the date of the closing of the authority loan, excluding funds used for~~

~~the purpose of documented improvements to the residence; (iii) improvements to be performed to the property after the closing of the authority loan and for which loan proceeds will be escrowed at closing; (iv) closing costs, discount points, fees and escrows payable in connection with the origination and closing of the authority loan; and (v) up to $500 to be payable to applicant or applicants at closing.~~

~~c. If the applicant or applicants request to receive loan proceeds at closing in excess of the limit set forth in clause (v) of subdivision 8 b of this section, the loan amount (plus all subordinate debt to be secured by the property after closing of the authority loan) may be increased to finance such excess cash up to a loan amount not in excess of 95% of the current appraised value. To be eligible for such increased financing, the applicant's or applicants' credit score may be no less than 660, and the financial integrity of the flexible alternative program must be protected by an upward adjustment to the rate of interest charged to the applicant or applicants or otherwise.~~

~~d. If the applicant's or applicants' existing mortgage loan to be refinanced is an authority mortgage loan, the applicant or applicants may request a streamlined refinance of the authority mortgage loan in which the authority may require less underwriting documentation (e.g., verification of employment) and may charge reduced points and fees. For such streamlined refinances, the loan amount (plus all subordinate debt to be secured by the property after closing of the authority loan) is limited to (i) the payoff of the existing authority mortgage loan and (ii) required closing costs, discount points, fees and escrows payable in connection with the origination and closing of the new authority loan, provided, however, that the loan amount (plus all subordinate debt to be secured by the property after closing of the authority loan) may not exceed 100% of the greatest of original appraised value, current real estate tax assessment, current appraised value or other alternative valuation method approved by the authority. To be eligible for such streamlined refinance, the applicant's or applicants' payment history on the current authority loan may not include any 30-day late payments within the previous 24-month period (12 months for applicants whose current authority loans do not carry mortgage insurance) and no bankruptcy since the closing of the original mortgage loan. In approving such streamlined refinance, the executive director must determine that any additional risk is outweighed by the demonstrated satisfactory payment history of applicant to the authority.~~

~~e. In addition to the foregoing maximum loan amounts under this section, the executive director may approve the disbursement of additional amounts to finance closing costs and fees and costs of rehabilitation and improvements to be completed subsequent to the closing. Except for loans financed under the program described in subdivision 24 of this subsection, these additional amounts may not exceed 5.0% of the lesser of sales price (if any) or appraised value, provided, however, that in addition to such 5.0%, amounts not to exceed 5.0% of the lesser of sales price (if any) or appraised value may be funded for the costs of rehabilitation and improvements to retrofit the residence or add accessibility features to accommodate the needs of a disabled occupant or to provide for visitability by disabled individuals.~~

~~9.~~ 6. Mortgage insurance shall not be required, ~~except that in the case of manufactured homes mortgage insurance shall be required in accordance with 13VAC10-40-120~~ unless the executive director determines that it is reasonable or necessary to protect the financial interests of the authority.

~~10. (Reserved.)~~

~~11. The applicant or applicants must have a history of receiving stable income from employment or other sources with a reasonable expectation that the income will continue in the foreseeable future; typically, verification of two years' stable income will be required; and education or training in a field related to the employment of the applicant or applicants may be considered to meet no more than one year of this requirement.~~

~~12. The applicant or applicants must possess a credit history as of the date of loan application satisfactory to the authority and, in particular, must satisfy the following: (i) for each applicant, no bankruptcy or foreclosure within the preceding three years; for each applicant, no housing payment past due for 30 days in the preceding 24 months; for a single applicant individually and all multiple applicants collectively, no more than one payment past due for 30 days or more on any other debt or obligation within the preceding 12 months; for each applicant, no outstanding collection, judgment, charge-off, repossession or 30-day past due account; and a minimum credit score of 620 if the loan-to-value ratio is 95% or less or 660 if the loan-to-value ratio exceeds 95% (credit scores as referenced in these regulations shall be determined by obtaining credit scores for each applicant from a minimum of three repositories and using the middle score in the case of a single applicant and the lowest middle score in the case of multiple applicants); or (ii) for each applicant, no previous bankruptcy or foreclosure; for a single applicant individually and all multiple applicants collectively, no outstanding collection, judgment, charge-off or repossession within the past 12 months or more than one 30-day past due account within the past 12 months and no more than four 30-day past due accounts within the past 24 months; for each applicant, no previous housing payment~~

~~past due for 30 days; for a single applicant individually and all multiple applicants collectively, minimum of three sources of credit with satisfactory payment histories for the most recent 24 month period; for a single applicant individually and all multiple applicants collectively, no more than nine accounts currently open; and for a single applicant individually and all multiple applicants collectively, no more than three new accounts opened in the past 12 months (in establishing guidelines to implement the flexible alternative mortgage loan programs, the authority may refer to the credit requirements in clause (i) of this subdivision as the "alternative" credit requirements and the requirements in clause (ii) of this subdivision as the "standard" credit requirements).~~

~~If the executive director determines it is necessary to protect the financial integrity of the flexible alternative program, the executive director may require that applicant or applicants for loans having loan to value ratios in excess of 97% meet the alternative credit requirements in clause (i) of this subdivision.~~

~~13. Homeownership education approved by the authority shall be required for any borrower who is a first time homeowner if the loan to value ratio exceeds 95%. This requirement shall be waived if the applicant or applicants have a credit score of 660 or greater (see subdivision 12 of this section for the manner of determining credit scores); unless the executive director determines that such homeownership education is necessary to protect its financial interests;~~

~~14. Seller contributions for closing costs and other amounts payable by the borrower or borrowers in connection with the purchase or financing of the property shall not exceed 4.0% of the contract price.~~

~~15. Sources of funds for the down payment and closing costs payable by the borrower shall be limited to the borrower's or borrowers' funds, gifts or unsecured loans from relatives, grants from employers or nonprofit entities not involved in the transfer or financing of the property, and unsecured loans on terms acceptable to the authority (payments on any unsecured loans permitted under this subdivision shall be included in the calculation of the debt/income ratios described below), and documentation of such sources of funds shall be in form and substance acceptable to the authority.~~

~~16. The maximum debt ratios shall be 35% and 43% in lieu of the ratios of 32% and 40%, respectively, set forth in 13VAC10-40-130 B 4.~~

~~17. Cash reserves at least equal to two months' loan payments must be held by the applicant or applicants if the loan to value ratio exceeds 95%; cash reserves at least equal to one month's loan payment must be held by the applicant or applicants if the loan to value ratio is greater than 90% and is less than or equal to 95%; and no cash reserves shall be required if the loan to value ratio is 90% or less.~~

~~18. The payment of points (a point being equal to 1.0% of the loan amount) in addition to the origination fee shall be charged as follows: if the loan to value ratio is 90% or less, one half of one point shall be charged; if the loan to value ratio is greater than 90% and is less than or equal to 95%, one point shall be charged; and if the loan to value ratio exceeds 95%, one and one half point shall be charged. If the executive director determines that the financial integrity of the flexible alternative program is protected, by an adjustment to the rate of interest charged to the applicant or applicants or otherwise, the authority may provide the applicant or applicants with the option of an alternative point requirement.~~

~~In addition to the above, a reduction of one half of one point will be made to the applicant or applicants meeting the credit requirements in clause 12 (i) above with a credit score of 700 or greater (see subdivision 12 of this section for the manner of determining credit scores).~~

~~19. The interest rate which would otherwise be applicable to the loan shall be reduced by.25% if the loan to value ratio is 80% or less.~~

~~20.~~ 7. The documents relating to requirements of the federal tax code governing tax-exempt bonds shall not be required.

~~21.~~ 8. For assumptions of loans, the ~~above~~ requirements for (i) occupancy of the property as the borrower's ~~or borrowers'~~ principal residence~~,~~ and (ii) the ~~above~~ income limit~~, and the underwriting criteria in the regulations as modified by~~ in this section must be satisfied.

~~22. The authority may require that any or all loans financed under such alternative mortgage programs be serviced by the authority.~~

~~23.~~ 9. The authority may accept an approval of an automated underwriting system ~~in lieu of satisfaction of the foregoing requirements for the flexible alternative program~~ if the executive director determines that such delegated underwriting system is designed so as to adequately protect the financial integrity of the ~~flexible alternative program~~ loan programs funded by taxable bonds.

~~24. The executive director may establish a flexible alternative rehabilitation mortgage loan program. The regulations set forth in subdivisions 1 through 23 of this section shall apply to such flexible alternative rehabilitation mortgage loan program, with the following modifications:~~

~~a. At the time of closing, each applicant must occupy or intend to occupy within 180 days the property to be financed as his principal residence;~~

~~b. The provision of clause (iii) of subdivision 4 of this section permitting the financing of a doublewide manufactured home permanently affixed to the land shall not apply.~~

~~c. The maximum loan amount for a purchase shall be 100% of the lesser of (i) the sum of purchase price plus rehabilitation costs; or (ii) the as completed appraised value. The maximum loan amount for a refinance shall be 100% of the lesser of (i) the outstanding principal balance plus rehabilitation costs; or (ii) the as completed appraised value.~~

~~d. The rehabilitation costs to be financed may not exceed an amount equal to 50% of the as completed appraised value.~~

~~e. Loan proceeds may be used to finance the purchase and installation of eligible improvements. Improvements that are eligible for financing are structural alterations, repairs, additions to the residence itself, or other improvements (including appliances) upon or in connection with the residence. In order to be eligible, such improvements must substantially protect or improve the basic livability or utility of the residence. Improvements that are physically removed from the residence but that are located on the property occupied by the residence may be eligible for financing if these improvements substantially protect or improve the basic livability or utility of the residence (i.e., installation of a septic tank or the drilling of a well). Luxury items (such as swimming pools and spas) shall not be eligible for financing hereunder.~~

~~f. Loan proceeds may not be used to finance any improvements that have been completed at the time the application is submitted to the authority.~~

~~g. All work financed with the loan proceeds shall be performed by a contractor duly licensed in Virginia to perform such work and be performed pursuant to a validly issued building permit, if required, and shall comply with all applicable state and local health, housing, building, fire prevention and housing maintenance codes and other applicable standards and requirements. Compliance with the foregoing shall be evidenced by such documents and certifications as shall be prescribed by the executive director.~~

~~h. The executive director may require the applicant or applicants to establish a contingency fund for the mortgage loan in an amount adequate to ensure sufficient reserve funds for the proper completion of the proposed improvements in the event of cost over runs. The executive director may also require a holdback from each disbursement of loan proceeds until completion of the residence.~~

~~i. The executive director may approve originating agents to originate the acquisition/rehabilitation loans. To be so approved, the originating agent must have a staff with demonstrated ability and experience in acquisition/rehabilitation mortgage loan origination, processing and administration.~~

~~j. In addition to the payment of points set forth in subdivision 18 of this section, the originating agent may collect an escrow administration fee and an inspection fee in an amount determined by the executive director to compensate the originating agent for administering the disbursement of the mortgage loan during the rehabilitation of the residence.~~

Except as modified ~~hereby~~ in this section, all ~~of the~~ requirements, terms [,] and conditions set forth in 13VAC10-40-10 through 13VAC10-40-220 shall apply to the ~~flexible alternative~~ mortgage loan programs established pursuant to this section.

13VAC10-40-240. Down payment and closing cost assistance grants.

The authority may make or finance down payment or closing cost assistance grants in connection with authority first mortgage loans. Such grants must meet the applicable insurer, guarantor, or investor requirements applicable to the first mortgage loan in addition to any additional requirements imposed by the executive director. Any such grants made or financed by the authority are not loans and no repayment shall be required. The executive director may establish lower maximum income limits in connection with such grants that enable the authority to effectively and efficiently allocate its current and anticipated financial resources so as to best meet the current and future housing needs of low and moderate income Virginians.

13VAC10-40-250. Government-sponsored enterprises programs.

A. The authority may make or finance mortgage loans pursuant to the requirements of Fannie Mae or Freddie Mac and may securitize and sell such mortgage loans to Fannie Mae or Freddie Mac, as applicable.

B. The following requirements shall not apply to government-sponsored enterprises programs: (i) the requirement that each applicant must not have had a present ownership interest in his principal residence within the preceding three years (the first-time homebuyer or three-year requirement); (ii) the maximum allowable sales prices in 13VAC10-40-80; and (iii) the net worth requirements in 13VAC10-40-90.

C. For the purposes of 13VAC10-40-100, gross income of applicants for Fannie Mae or Freddie Mac loans shall be determined in accordance with the requirements of Fannie Mae or Freddie Mac, as applicable.

13VAC10-40-260. FHA, VA, or Rural Development streamline refinance program.

A. The authority may make or finance streamline refinance loans that refinance existing authority FHA, VA, and Rural Development loans pursuant to the requirements of FHA for streamline refinances, the requirements of the VA for interest rate reduction refinance loans, and the requirements of Rural Development for streamlined refinances, as applicable.

B. The following requirements shall not apply to streamline refinance programs: (i) the requirement that each applicant must not have had a present ownership interest in his principal residence within the preceding three years (the first-time homebuyer or three-year requirement); (ii) the maximum allowable sales prices in 13VAC10-40-80; (iii) the net worth requirements in 13VAC10-40-90; and (iv) the underwriting requirement regarding income verification set forth in 13VAC10-40-130 A 1.

C. The income limits for applicants for FHA, VA, or Rural Development streamline refinances shall in no event exceed 150% of the greater of the applicable area or statewide median family income.

D. The condominium approval requirement in 13VAC10-40-210 A is modified so that withdrawn FHA, VA, Fannie Mae, or Freddie Mac condominium approvals are acceptable.

13VAC10-40-270. Real estate owned condo program.

A. The authority may make or finance mortgage loans on authority real estate owned (REO) condominiums pursuant to the loan program provisions set forth in 13VAC10-40-230 (mortgage loan programs funded by taxable bonds), except as altered by the provisions of this section.

B. The new mortgage requirement shall apply to REO condo loans (refinances are not permitted under this program).

C. For purposes of subdivision 2 of 13VAC10-40-230, the income limits for applicants for REO condo loans shall be (i) for applicants with a household size of one person, 120% of the greater of the applicable area or statewide median family income and (ii) for applicants with a household size of two or more persons, 150% of the greater of the applicable area or statewide median family income.

D. The requirement in subdivision 4 of 13VAC10-40-230 that a condominium unit must be approved by Fannie Mae or Freddie Mac or satisfy the requirements for their financing shall not apply.

E. The maximum loan amount for REO condo loans shall be 97% of the lesser of the sales price or appraised value.

F. The minimum credit score shall be 660 for all applicants, regardless of loan-to-value ratios.

G. The maximum debt ratios for REO condo loans shall be 35% and 45%.

13VAC10-40-280. Reduced rate financing.

The authority may make or finance mortgage loans with an allocation of reduced rate funding to local governments, nonprofits, and housing industry partners to support special housing needs. Such reduced rate funding must meet the applicable insurer, guarantor, or investor requirements applicable to the first mortgage loan in addition to any additional requirements imposed by the executive director.

NOTICE: Forms used in administering the regulation have been 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 (13VAC10-40)

Uniform Residential Loan Application, Freddie Mac Form 65 [/Fannie Mae Form 1003] (rev. 6/2009)

VA.R. Doc. No. R19-5800; Filed February 15, 2019, 9:34 a.m.

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: **13VAC10-190. Rules and Regulations for Qualified Mortgage Credit Certificate Programs (amending 13VAC10-190-10, 13VAC10-190-30 through 13VAC10-190-70, 13VAC10-190-200).**

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

Effective Date: March 4, 2019.

Agency Contact: Jeff Quann, Senior Counsel, Virginia Housing Development Authority, 601 South Belvidere Street, Richmond, VA 23220, telephone (804) 343-5603 or email jeffrey.quann@vhda.com.

Summary:

The amendments update the mortgage credit certificate (MCC) regulations for consistency with other regulations, including (i) adding definitions and (ii) clarifying regulatory language and conditions under which the authority may issue an MCC to an applicant.

13VAC10-190-10. Definitions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Qualified home improvement loan" has the meaning set forth in IRC § 143(k)(4).

"Qualified mortgage bond" has the meaning set forth in IRC § 143.

"Qualified rehabilitation loan" has the meaning set forth in IRC § 143(k)(5).

"Qualified veteran's mortgage bond" has the meaning set forth in IRC § 143.

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

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

B. This chapter is intended to provide a general description of the authority's requirements and processing and is not intended to include all actions involved or required in the processing and administration of MCCs. This chapter is subject to amendment by the authority at any time and may be supplemented by policies, rules, and regulations adopted by the authority from time to time with respect to all of the programs.

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

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

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

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

13VAC10-190-40. Eligible persons.

The authority may only issue an MCC to an ~~individual only if he would be eligible to be a borrower of a tax exempt bond financed loan pursuant to 13VAC10-40-30, 13VAC10-40-40, 13VAC10-40-50, 13VAC10-40-70, 13VAC10-40-90, and 13VAC10-40-100~~ applicant if the applicant meets the requirements the authority establishes for the program, which include requirements that ensure the applicant qualifies under 26 CFR 1.25-3T so that the MCC would be a qualified mortgage credit certificate pursuant to 26 CFR 1.25-3T.

13VAC10-190-50. Eligible properties.

The authority may issue an MCC to an ~~individual~~ applicant only if his application for the MCC is based upon his purchasing a principal residence that qualifies under 26 CFR 1.25-3T so that the MCC would be ~~eligible for a tax exempt bond financed loan~~ a qualified mortgage credit certificate pursuant to ~~13VAC10-40-40 through 13VAC10-40-80~~ 26 CFR 1.25-3T.

13VAC10-190-60. Eligible lenders.

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

13VAC10-190-70. Eligible loans.

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

1. Is not funded in whole or in part from the proceeds of a qualified mortgage bond or a qualified veteran's mortgage bond ~~as defined in IRC § 143~~,

2. Is incurred by the applicant to acquire his principal residence,

3. Is not being assumed from another borrower, ~~and~~

4. Is not a refinancing of other indebtedness of the applicant, except in the case of construction period loans, bridge loans, or similar temporary financing that has a term of 24 months or less,

5. Is not a qualified home improvement loan or a qualified rehabilitation loan, and

6. Otherwise satisfies the requirements of 26 CFR 1.25-2T(c)(1).

13VAC10-190-200. Compliance investigations.

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

VA.R. Doc. No. R19-5801; Filed February 15, 2019, 9:32 a.m.

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

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 in Schedule I or II pursuant to subsection D 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 18VAC110-20-322).**

Statutory Authority: §§ 54.1-2400 and 54.1-3443 of the Code of Virginia.

Effective Date: April 3, 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 amendments add six compounds into Schedule I of the Drug Control Act as recommended by the Virginia Department of Forensic Science pursuant to § 54.1-3443 of the Code of Virginia. The compounds added by this regulatory action will remain in effect for 18 months or until the compounds are placed in Schedule I by legislative action of the General Assembly. A technical amendment corrects the date until which the compounds listed in subsection C of the regulation remain in effect.

18VAC110-20-322. Placement of chemicals in Schedule I.

A. Pursuant to subsection D of § 54.1-3443 of the Code of Virginia, the Board of Pharmacy places the following in Schedule I of the Drug Control Act:

1. 2-(methylamino)-2-phenyl-cyclohexanone (other name: Deschloroketamine), its optical, position, and geometric isomers, salts, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation.

2. 2-methyl-1-(4-(methylthio)phenyl)-2-morpholinopropiophenone (other name: MMMP), its optical, position, and geometric isomers, salts, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation.

3. Alpha-ethylaminohexanophenone (other name: N-ethylhexedrone), its optical, position, and geometric isomers, salts, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation.

4. N-ethyl-1-(3-methoxyphenyl)cyclohexylamine (other name: 3-methoxy-PCE), its optical, position, and geometric isomers, salts, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation.

5. 4-fluoro-alpha-pyrrolidinohexiophenone (other name: 4-fluoro-alpha-PHP), its optical, position, and geometric isomers, salts, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation.

6. N-ethyl-1,2-diphenylethylamine (other name: Ephenidine), its optical, position, and geometric isomers, salts, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation.

7. Synthetic opioids:

a. N-phenyl-N-[1-(2-phenylethyl)-4-piperidinyl]-1,3-benzodioxole-5-carboxamide (other name: Benzodioxole fentanyl), its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, unless specifically excepted, whenever the existence of these isomers, esters, ethers, and salts is possible within the specific chemical designation.

b. 3,4-dichloro-N-[2-(diethylamino)cyclohexyl]-N-methylbenzamide (other name: U-49900), its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, unless specifically excepted, whenever the existence of these isomers, esters, ethers, and salts is possible within the specific chemical designation.

c. 2-(2,4-dichlorophenyl)-N-[2-(dimethylamino) cyclohexyl]-N-methylacetamide (other name: U-48800), its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, unless specifically excepted, whenever the existence of these isomers, esters, ethers, and salts is possible within the specific chemical designation.

8. Central nervous system stimulants:

a. Methyl 2-(4-fluorophenyl)-2-(2-piperidinyl)acetate (other name: 4-fluoromethylphenidate), including its salts, isomers, and salts of isomers.

b. Isopropyl-2-phenyl-2-(2-piperidinyl)acetate (other name: Isopropylphenidate), including its salts, isomers, and salts of isomers.

The placement of drugs listed in this subsection shall remain in effect until August 21, 2019, unless enacted into law in the Drug Control Act.

B. Pursuant to subsection D of § 54.1-3443 of the Code of Virginia, the Board of Pharmacy places the following in Schedule I of the Drug Control Act:

1. Research chemicals:

a. 2-(ethylamino)-2-phenyl-cyclohexanone (other name: deschloro-N-ethyl-ketamine), its optical, position, and geometric isomers, salts, and salts of isomers, whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation.

b. 3,4-methylenedioxy-N-tert-butylcathinone, its optical, position, and geometric isomers, salts, and salts of isomers, whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation.

c. 4-fluoro-N-ethylamphetamine, its optical, position, and geometric isomers, salts, and salts of isomers, whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation.

d. Beta-keto-4-bromo-2,5-dimethoxyphenethylamine (other name: bk-2C-B), its optical, position, and geometric isomers, salts, and salts of isomers, whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation.

2. Synthetic opioids:

a. N-phenyl-N-[1-(2-phenylethyl)-4-piperidinyl]-2butenamide (other name: Crotonyl fentanyl), its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, unless specifically excepted, whenever the existence of these isomers, esters, ethers, and salts is possible within the specific chemical designation.

b. 2-(3,4-dichlorophenyl)-N-[2-(dimethylamino) cyclohexyl]-N-methylacetamide (other name: U-51754), its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, unless specifically excepted, whenever the existence of these isomers, esters, ethers, and salts is possible within the specific chemical designation.

c. N-phenyl-N-[4-phenyl-1-(2-phenylethyl)-4piperidinyl]-propanamide (other name: 4phenylfentanyl), its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, unless specifically excepted, whenever the existence of these isomers, esters, ethers, and salts is possible within the specific chemical designation.

The placement of drugs listed in this subsection shall remain in effect until December 12, 2019, unless enacted into law in the Drug Control Act.

C. Pursuant to subsection D of § 54.1-3443 of the Code of Virginia, the Board of Pharmacy places the following in Schedule I of the Drug Control Act:

1. 2,5-dimethoxy-4-chloroamphetamine (other name: DOC), its optical, position, and geometric isomers, salts, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation.

2. Synthetic opioids:

a. N-(2-fluorophenyl)-2-methoxy-N-[1-(2-phenylethyl)-4-piperidinyl]-acetamide (other name: Ocfentanil), its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, unless specifically excepted, whenever the existence of these isomers, esters, ethers, and salts is possible within the specific chemical designation.

b. N-(4-methoxyphenyl)-N-[1-(2-phenylethyl)-4-piperidinyl]-butanamide (other name: 4-methoxybutyrylfentanyl), its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, unless specifically excepted, whenever the existence of these isomers, esters, ethers, and salts is possible within the specific chemical designation.

c. N-phenyl-2-methyl-N-[1-(2-phenylethyl)-4-piperidinyl]-propanamide (other name: Isobutyryl fentanyl), its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, unless specifically excepted, whenever the existence of these isomers, esters, ethers, and salts is possible within the specific chemical designation.

d. N-phenyl-N-[1-(2-phenylethyl)-4-piperidinyl]-cyclopentanecarboxamide (other name: Cyclopentyl fentanyl), its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, unless specifically excepted, whenever the existence of these isomers, esters, ethers, and salts is possible within the specific chemical designation.

e. N-phenyl-N-(1-methyl-4-piperidinyl)-propanamide (other name: N-methyl norfentanyl), its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, unless specifically excepted, whenever the existence of these isomers, esters, ethers, and salts is possible within the specific chemical designation.

3. Cannabimimetic agent: 1-(4-cyanobutyl)-N-(1-methyl-1-phenylethyl)-1H-indazole-3-carboxamide (other name: 4-cyano CUMYL-BUTINACA), its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation.

4. Benzodiazepine: Flualprazolam, its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation.

The placement of drugs listed in this subsection shall remain in effect until March 4, ~~2019~~ 2020, unless enacted into law in the Drug Control Act.

D. Pursuant to subsection D of § 54.1-3443 of the Code of Virginia, the Board of Pharmacy places the following in Schedule I of the Drug Control Act:

1. Synthetic opioid: N-[2-(dimethylamino)cyclohexyl]-N-methyl-1,3-benzodioxole-5-carboxamide (other names: 3,4-methylenedioxy U-47700 or 3,4-MDO-U-47700), its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, unless specifically excepted, whenever the existence of these isomers, esters, ethers, and salts is possible within the specific chemical designation.

2. Cannabimimetic agent: N-(adamantanyl)-1-(5-chloropentyl) indazole-3-carboxamide (other name: 5-chloro-AKB48), its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation.

The placement of drugs listed in this subsection shall remain in effect until May 27, 2020, unless enacted into law in the Drug Control Act.

E. Pursuant to subsection D of § 54.1-3443 of the Code of Virginia, the Board of Pharmacy places the following in Schedule I of the Drug Control Act:

1. Synthetic opioid: N-phenyl-N-[1-(2-phenylethyl)-4-piperidinyl]-benzamide (other names: Phenyl fentanyl, Benzoyl fentanyl), its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, unless specifically excepted, whenever the existence of these isomers, esters, ethers, and salts is possible within the specific chemical designation.

2. Research chemicals:

a. 4-acetyloxy-N,N-diallyltryptamine (other name: 4-AcO-DALT), its optical, position, and geometric isomers, salts, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation.

b. 4-chloro-N,N-dimethylcathinone, its optical, position, and geometric isomers, salts, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation.

c. 4-hydroxy-N,N-methylisopropyltryptamine (other name: 4-hydroxy-MiPT), its optical, position, and geometric isomers, salts, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation.

d. 3,4-Methylenedioxy-alpha-pyrrolidinohexanophenone (other name: MDPHP), its optical, position, and

geometric isomers, salts, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation.

3. Cannabimimetic agent: Methyl 2-[1-(5-fluoropentyl)-1H-indole-3-carboxamido]-3,3-dimethylbutanoate (other name: 5-Fluoro-MDMB-PICA), its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation.

The placement of drugs listed in this subsection shall remain in effect until October 2, 2020, unless enacted into law in the Drug Control Act.

VA.R. Doc. No. R19-5776; Filed February 7, 2019, 1:59 p.m.

GUIDANCE DOCUMENTS

PUBLIC COMMENT OPPORTUNITY

Pursuant to § 2.2-4002.1 of the Code of Virginia, a certified guidance document is subject to a 30-day public comment period after publication in the Virginia Register of Regulations and prior to the guidance document's effective date. During the initial or additional public comment period, comments may be made through the Virginia Regulatory Town Hall website (http://www.townhall.virginia.gov) or sent to the agency contact. Under subsection C of § 2.2-4002.1, the effective date of the guidance document may be delayed for an additional comment period.

The following guidance documents have been submitted for publication by the listed agencies to initiate or extend a public comment period. Online users of this issue of the Virginia Register of Regulations may click on the name of a guidance document to access it. Guidance documents are also available on the Virginia Regulatory Town Hall (http://www.townhall.virginia.gov) or from the agency contact or may be viewed at the Office of the Registrar of Regulations, 900 East Main Street, Richmond, Virginia 23219.

DEPARTMENT FOR AGING AND REHABILITATIVE SERVICES

Title of Document: Area Agency on Aging Service Standards.

Public Comment Deadline: April 3, 2019.

Effective Date: April 4, 2019.

Agency Contact: Charlotte Arbogast, Senior Policy Advisor, Department for Aging and Rehabilitative Services, 8004 Franklin Farms Drive, Richmond, VA 23229, telephone (804) 662-7093, FAX (804) 662-7663, or email charlotte.arbogast@dars.virginia.gov.

BOARD FOR ASBESTOS, LEAD, AND HOME INSPECTORS

Title of Document: Requirement to Take the Virginia Lead Law Examination.

Public Comment Deadline: April 3, 2019.

Effective Date: April 4, 2019.

Agency Contact: Trisha L. Henshaw, Executive Director, Board for Asbestos, Lead, and Home Inspectors, 9960 Mayland Drive, Suite 400, Richmond, VA 23233, telephone (804) 367-8595, FAX (804) 350-5354, or email alhi@dpor.virginia.gov.

STATE BOARD OF EDUCATION

Title of Document: Model Guidance for Positive and Preventive Code of Student Conduct Policy and Alternatives to Suspension.

Public Comment Deadline: April 3, 2019.

Effective Date: April 4, 2019.

Agency Contact: Maribel Saimre, Director of Student Services, Department of Education, 101 North 14th Street, Richmond, VA 23219, telephone (804) 225-2818, or email maribel.saimre@doe.virginia.gov.

BOARD OF NURSING

Titles of Documents:

90-2, Transmittal of Orders by Authorized Agents to Nurses, revised January 29, 2019.

90-3, Continued Competency Violations for Nurses, revised January 29, 2019.

90-12, Delegation of Authority to Board of Nursing RN Education and Discipline Staff, revised January 29, 2019.

90-22, Requests for Accommodation for NCLEX and NNAAP Testing and Medication Aide Examination for Registration, revised January 29, 2019.

90-31, Administer a Medication that Has Been Transmitted Orally or in Writing by a Pharmacist Acting as the Prescriber's Agent, revised January 29, 2019.

90-35, Noncompliance with Board Orders by Individual Licensees, revised January 29, 2019.

90-38, Disposition of Disciplinary Cases against Nurses and Massage Therapists Practicing on Expired Licenses, revised January 29, 2019.

90-61, Disposition of Disciplinary Cases against Certified Nurse Aides and Registered Medication Aides Practicing on Expired Certificates or Registrations, revised January 29, 2019.

Public Comment Deadline: April 3, 2019.

Effective Date: April 4, 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.

BOARD OF OPTOMETRY

Title of Document: Guidance for Continuing Education (CE) Audits and Sanctioning for Failure to Complete CE.

Public Comment Deadline: April 3, 2019.

Effective Date: April 4, 2019.

Agency Contact: Leslie L. Knachel, Executive Director, Board of Optometry, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4508, FAX (804) 527-4471, or email, leslie.knachel@dhp.virginia.gov.

ANNUAL LIST

Section 2.2-4103.1 of the Code of Virginia requires annual publication in the Virginia Register of Regulations of guidance document lists from state agencies. A guidance document is defined as "…any document developed by a state agency or staff that provides information or guidance of general applicability to the staff or public to interpret or implement statutes or the agency's rules or regulations..." Agencies are required to maintain a complete, current list of all guidance documents and make the full text of such documents available to the public.

Generally, the format for the guidance document list is: document number (if any), title of document, date issued or last revised, and citation of Virginia Administrative Code regulatory authority or Code of Virginia statutory authority. Questions concerning documents or requests for copies of documents should be directed to the contact person listed by the agency.

DEPARTMENT OF EMERGENCY MANAGEMENT

Copies of the guidance document may be viewed at http://www.vaemergency.gov/em-community/plans/2012COVEOP. The document may be printed without restrictions.

Questions regarding interpretation or implementation of this document may be directed to Dillon Taylor, Policy Analyst, State Coordinator's Office, Virginia Department of Emergency Management, 10501 Trade Court, Richmond, VA 23236, telephone (804) 543-0055, or email dillon.taylor@vdem.virginia.gov.

Guidance Document:

COVEOP, Commonwealth of Virginia Emergency Operations Plan, 9/1/2011

MARINE RESOURCES COMMISSION

Documents are available on the Virginia Regulatory Town Hall at http://townhall.virginia.gov. Questions regarding interpretation or implementation of habitat documents may be directed to Tony Watkinson, Chief, Habitat Division, Marine Resources Commission, Newport News, VA 23607, telephone (757) 247-2250, or FAX (757) 247-8062.

Questions regarding interpretation or implementation of law-enforcement documents may be directed to Colonel Rick Lauderman, Chief, Law Enforcement Division, Marine Resources Commission, Newport News, VA 23607, telephone (757) 247-2278, or FAX (757) 247-2020.

Guidance Documents:

4582, Rent and Royalty Guidelines, 12/1/2005

4583, Resolution by the VMRC Citizen Board Interpreting § 28.2-1203 a 5 (iv) of the Code of Virginia and Delegating Authority to make the Determination Called for by § 28.2-1203 a 5 (iv), 12/6/2011

4584, Coastal Primary Sand Dune/Beaches Guidelines, 10/1/1990

4585, Guidelines for Establishment, Use and Operation of Tidal Wetland Mitigation Banks, 12/6/2011

4586, Subaqueous Guidelines, 10/1/2005

4587, Wetlands Guidelines, 12/1/1982

4588, Guidelines on Repeat Offenders - Appendix A, 8/22/2017

Revocation Orders, Guidelines on the Scope of License and Privilege Revocation Orders Issued under § 28.2-232 of the Code of Virginia, 7/27/2016

ALCHOLIC BEVERAGE CONTROL AUTHORITY

Small Business Impact Review - Report of Findings

Pursuant to § 2.2-4007.1 of the Code of Virginia, the Alcoholic Beverage Control Authority conducted a small business impact review of **3VAC5-11, Public Participation Guidelines**, and determined that this regulation should be retained in its current form. The Alcoholic Beverage Control Authority is publishing its report of findings dated February 4, 2019, to support this decision in accordance with § 2.2-4007.1 F of the Code of Virginia.

The regulation continues to be needed as it outlines the procedures for the public to engage in the regulatory process as well as being necessary for the agency to comply with § 4.1-103 of the Code of Virginia. The agency did not receive any complaints or comments from the public during the periodic review. The regulation is easy to understand and clearly written. The regulation is not redundant nor does it conflict with other federal or state regulations. The regulation was last evaluated in 2012. No small business impact has been identified.

Contact Information: LaTonya D. Hucks-Watkins, Legal Liaison, Alcoholic Beverage Control Authority, 2901 Hermitage Road, Richmond, VA 23220, telephone (804) 213-4698, FAX (804) 213-4574, or email latonya.hucks@abc.virginia.gov.

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

Approval of Variances to the Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Behavioral Health and Developmental Services

Notice of action: The Department of Behavioral Health and Developmental Services (DBHDS), in accordance with Part VI, Variances (12VAC35-115-220), of the Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Behavioral Health and Developmental Services (12VAC35-115), hereafter referred to as the "Human Rights Regulations," is announcing a decision by the State Human Rights Committee (SHRC) on an application for proposed variances to the Human Rights Regulations. The purpose of the regulations is to ensure and protect the legal and human rights of individuals receiving services in facilities or programs operated, licensed, or funded by DBHDS.

Each variance application references the specific part of the regulations to which a variance is needed, the proposed wording of the substitute rule or procedure, and the justification for a variance. Such application also describes time limits and other conditions for duration and the circumstances that will end the applicability of the variance. All variances shall be approved for a specific time period. Variances to the Human Rights Regulations by the listed state facility are reviewed by the SHRC at least annually, with reports to the SHRC regarding the variances as requested.

The variances must comply with the general requirements of Part VI, Variances (12VAC35-115-220), of the Human Rights Regulations.

Purpose of notice: After considering all available information at its meeting on January 31, 2019, the SHRC voted to approve the application for variances to the Human Rights Regulations for Western State Hospital (WSH). A public comment period was held from November 26, 2018, through December 26, 2018. Two comments were received. The variances were approved for a three-year period with semiannual updates to the SHRC and quarterly review by the local human rights committee.

Variance to Procedures for Behavioral Treatment Plans:

12VAC35-115-105 H: Providers shall not use seclusion in a behavioral treatment plan.

Variance to Procedures for Use of Seclusion, Restraint, and Time Out:

12VAC35-115-110 C 3: Only residential facilities for children that are licensed under the Regulations for Children's Residential Facilities (12VAC35-46), and inpatient hospitals may use seclusion and only in an emergency.

Explanation: The variances allow WSH to place an individual in an environment of seclusion at the individual's request and not as related to an emergency, in order to prevent self-injurious harm to the individual and to the staff members responsible for the individual's care.

Contact Information: Deborah Lochart, Director, Office of Human Rights, Department of Behavioral Health and Developmental Services, 1220 East Bank Street, P.O. Box 1797, Richmond, VA 23218-1797, telephone (804) 786-0032, FAX (804) 804-371-2308, or email deb.lochart@dbhds.virginia.gov.

Public Comment on Proposed Variances to the Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Behavioral Health and Developmental Services

Notice of action: The Department of Behavioral Health and Developmental Services (DBHDS), in accordance with Part VI, Variances (12VAC35-115-220), of the Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Behavioral Health and Developmental Services (12VAC35-115), hereafter referred to as the "Human Rights

Regulations," is announcing an opportunity for public comment on an application for proposed variances to the Human Rights Regulations submitted to the State Human Rights Committee (SHRC). The purpose of the regulations is to ensure and protect the legal and human rights of individuals receiving services in facilities or programs operated, licensed, or funded by DBHDS.

Each variance application references the specific part of the regulations to which a variance is needed, the proposed wording of the substitute rule or procedure, and the justification for a variance. Such application also describes time limits and other conditions for the duration and circumstances that will end the applicability of the variance. After considering all available information including comments, the SHRC intends to submit a written decision deferring, disapproving, modifying, or approving each variance application. All variances shall be approved for a specific time period. The decision and reasons for variance will be published in a later issue of the Virginia Register of Regulations.

Purpose of notice: The SHRC is seeking public comment on the application for proposed new variances to the Human Rights Regulations for the Virginia Center for Behavioral Rehabilitation (VCBR).

Variance to Procedures for Restrictions on Freedoms of Everyday Life, 12VAC35-115-100 B 3 a through B 3 e.

Requirements for the Imposition of Restrictions: The proposed variance would permit VCBR to place a resident on restrictions temporarily, without first meeting the criteria set forth in 12VAC35-115-100 B 3 a through B 3 e, if a resident displays behavior that is determined to be an immediate threat to the safety and security of the facility or the community.

Explanation: Individuals deemed by the court to be "sexually violent predators" may engage in behavior that requires an immediate response to ensure the safety of individuals in the facility and the community. An appropriate response may be an immediate restriction on the freedoms of everyday life as outlined in 12VAC35-115-100 A 1 a through A 1 g. The immediate need to protect the safety and security of the facility or the community may be jeopardized by the process outlined in 12VAC35-115-100 B 3 a through B 3 e.

When immediate restrictions are imposed to ensure the safety and security of the facility or the community, such restrictions shall be in effect only until the next business day that the restricted resident's treatment team is able to meet, review the imposed restriction, and meet the requirements set forth in 12VAC35-115-100 B 3 a through B 3 e.

Procedures for ensuring residents' freedoms of everyday life within VCBR and procedures for implementing restrictions on those freedoms shall be outlined in Facility Instruction No. 201, Restrictions on Freedoms of Everyday Life.

Variances to these regulations by the listed state facility are reviewed by the SHRC at least annually, with reports to the SHRC regarding the variances as requested.

Public comment period: February 18, 2019, through March 19, 2019.

How to comment: The SHRC accepts written comments by email, fax, and postal mail. In order to be considered, comments must include the full name, address, and telephone number of the person commenting and be received by DBHDS, who will provide them to the SHRC, by the last day of the comment period. All information received is part of the public record.

To review a proposal: Variance applications and any supporting documentation may be obtained by contacting the listed DBHDS representative.

Contact Information: Deborah Lochart, Director, Office of Human Rights, Department of Behavioral Health and Developmental Services, 1220 East Bank Street, P.O. Box 1797, Richmond, VA 23218-1797, telephone (804) 786-0032, FAX (804) 804-371-2308, or email deb.lochart@dbhds.virginia.gov.

DEPARTMENT OF ENVIRONMENTAL QUALITY

Dominion Energy Notice of Intent Small Renewable Energy Project (Solar) Permit by Rule - Greensville County

Dominion Energy has provided the Department of Environmental Quality (DEQ) a notice of intent to submit the necessary documentation for a permit by rule for a small renewable energy project (Sadler Solar) in Greensville County. The project will be located on approximated 1,490 acres at 3119 Dry Bread Road, Greensville County (Latitude 36.68875, Longitude -77.604208). The solar facility will be comprised of ground-mounted, fixed-tilt photovoltaic arrays and auxiliary equipment to provide approximately 102 megawatts alternating current of nameplate capacity. The project conceptually consists of 346,248 panels.

Contact Information: Mary E. Major, Department of Environmental Quality, 1111 East Main Street, Suite 1400, P.O. Box 1105, Richmond, VA 23218, telephone (804) 698-4423, FAX (804) 698-4319, or email mary.major@deq.virginia.gov.

Mount Nebo Solar Partners LLC Notice of Intent Small Renewable Energy Project (Solar) Permit by Rule - Surry County

Mount Nebo Solar Partners LLC has provided the Department of Environmental Quality (DEQ) a notice of intent to submit the necessary documentation for a permit by rule for a small renewable energy project (solar) in Surry County. The proposed project will be located along Colonial Trail East approximately three miles east of Surry. The

project will have a maximum generating capacity of 20 megawatts alternating current across approximately 80.2 acres. The project is located at 37°7'3.78"N, 76°47'12.20"W. The project will use approximately 38,000 solar panels mounted to single-axis trackers that will follow the path of the sun throughout the day.

Contact Information: Mary E. Major, Department of Environmental Quality, 1111 East Main Street, Suite 1400, P.O. Box 1105, Richmond, VA 23218, telephone (804) 698-4423, FAX (804) 698-4319, or email mary.major@deq.virginia.gov.

BOARD OF HISTORIC RESOURCES

Small Business Impact Review - Report of Findings

Pursuant to § 2.2-4007.1 of the Code of Virginia, the Board of Historic Resources conducted a small business impact review of **17VAC5-30, Evaluation Criteria and Procedures for Designations by the Board of Historic Resources**, and determined that this regulation should be retained in its current form. The Board of Historic Resources is publishing its report of findings dated February 7, 2019, to support this decision in accordance with § 2.2-4007.1 F of the Code of Virginia.

This regulation continues to be needed to meet the requirements of state law and regulations concerning the evaluation criteria and procedures for designations by the Board of Historic Resources. No complaints or public comments have been received concerning the content of the regulation or its complexity. The regulation sets out the state requirements for evaluating criteria and procedures and does not overlap, duplicate, or conflict with other state laws or regulations.

Contact Information: Stephanie Williams, Deputy Director, Department of Historic Resources, 2801 Kensington Avenue, Richmond, VA 23221, telephone (804) 482-6082, FAX (804) 367-2391, or email stephanie.williams@dhr.virginia.gov.

DEPARTMENT OF HISTORIC RESOURCES

Small Business Impact Review - Report of Findings

Pursuant to § 2.2-4007.1 of the Code of Virginia, the Department of Historic Resources conducted a small business impact review of **17VAC10-20, Evaluation Criteria and Procedures for Nominations of Property to the National Register or for Designation as a National Historic Landmark**, and determined that this regulation should be retained in its current form. The Department of Historic Resources is publishing its report of findings dated February 7, 2019, to support this decision in accordance with § 2.2-4007.1 F of the Code of Virginia.

This regulation continues to be needed to meet the requirements of federal and state law concerning the evaluation criteria and procedures for nominations of property to the National Register or for designation as a National Historic Landmark. No complaints or public comments have been received concerning the content of the regulation or its complexity. The regulation sets out the federal and state requirements for evaluating criteria and procedures and does not overlap, duplicate, or conflict with other federal or state laws or regulations.

Contact Information: Stephanie Williams, Deputy Director, Department of Historic Resources, 2801 Kensington Avenue, Richmond, VA 23221, telephone (804) 482-6082, FAX (804) 367-2391, or email stephanie.williams@dhr.virginia.gov.

BOARD OF HOUSING AND COMMUNITY DEVELOPMENT

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 of Housing and Community Development is conducting a periodic review and small business impact review of each listed regulation. The review of each regulation will be guided by the principles in Executive Order 14 (as amended July 16, 2018).

13VAC5-11, Public Participation Guidelines

13VAC5-80, Virginia Standards for Individual and Regional Code Academies

13VAC5-200, Solar Energy Criteria for Tax Exemption

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 March 4, 2019, and ends April 3, 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 Kyle Flanders, Senior Policy Analyst, Department of Housing and Community Development, 600 East Main Street, Suite 300, Richmond, VA 23219, telephone (804) 786-6761, FAX (804) 371-7090, or email kyle.flanders@dhcd.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 Virginia Regulatory 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

Opportunity to Review and Comment on Draft Community Mental Health Rehabilitative Services Provider Manual for Stakeholder Input

Comment period: February 4, 2019, through March 6, 2019.

Changes to the Community Mental Health Rehabilitative Services Provider Manuals are now posted on the Department of Medical Assistance Services (DMAS) website at http://www.dmas.virginia.gov/#/manualdraft for public comment through March 6, 2019. The manuals will be finalized and officially posted by March 8, 2019.

Finalized DMAS provider manuals can be found at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual.

Contact Information: Emily McClellan, Regulatory Manager, Division of Policy and Research, Department of Medical Assistance Services, 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.

Renewal of FAMIS MOMS and FAMIS Select Title XXI § 1115 Demonstration Waiver

Comment period: March 4, 2019, through April 4, 2019.

Pursuant to 42 CFR 431.408, DMAS is providing a follow-up notice of intent to submit to the federal Centers for Medicare and Medicaid Services (CMS) a request to extend for five years its Title XXI § 1115 Demonstration for the FAMIS MOMS and FAMIS Select programs with no changes. The FAMIS MOMS and FAMIS Select demonstration is currently set to expire on June 30, 2019.

DMAS provided an initial opportunity to review and provide input on the FAMIS MOMS and FAMIS Select § 1115 Demonstration Extension November 13, 2018, through December 13, 2018. During that initial public notice period, two public hearings were held, one on November 30, 2018, and the other December 6, 2018.

DMAS is now providing a second opportunity for the public to review and provide input on the FAMIS MOMS and FAMIS Select § 1115 Demonstration Extension, which has been modified to provide additional information and clarity on how demonstration objectives have been met, how the demonstration will be evaluated for continued success, and actual and projected program enrollment and costs. This public comment period will be open from March 4, 2019, through April 4, 2019.

Virginia's Title XXI Children's Health Insurance Program (CHIP) covers children with family income from 143% to 200% of the federal poverty level (FPL) under a separate child health plan known as the Family Access to Medical Insurance Security (FAMIS) Plan. Virginia's Title XXI § 1115 Demonstration has two components. First, it expands Title XXI coverage to uninsured pregnant women with family income up to 200% of the federal poverty level (FPL) who are not eligible for Medicaid through a program known as FAMIS MOMS. Second, it uses Title XXI funds to support a health insurance premium assistance program known as FAMIS Select. To qualify, children must first be found eligible and enroll in FAMIS before electing to receive coverage through FAMIS Select.

The goals of Virginia's Title XXI HIFA Demonstration are as follows:

For FAMIS MOMS:

- Facilitate access to prenatal, obstetric, and postpartum care for a vulnerable population that does not otherwise qualify for public insurance;
- Improve selected birth outcomes of FAMIS MOMS participants and their newborns; and
- Facilitate access to recommended pediatric primary care for newborns of FAMIS MOMS participants.

For FAMIS Select:

- Facilitate access to affordable private and employer-sponsored health insurance for low-income families through premium assistance;
- Ensure that access to and use of health care services available to children participating in FAMIS Select is comparable to that of children participating in FAMIS; and
- Assure the aggregate cost-effectiveness of the FAMIS Select program.

To read the FAMIS MOMS and FAMIS Select demonstration full public notice and to view the draft FAMIS MOMS and FAMIS Select demonstration renewal application, please visit the DMAS website at http://www.dmas.virginia.gov/#/hifawaiver.

To read the most recent Prenatal Care and Birth Outcomes Focused Study reports from the DMAS External Quality Review Organization (EQRO), please visit http://www.dmas.virginia.gov/#/med3studies.

Public Comment: All comments must be received by 11:59 p.m. (Eastern Time) on Thursday, April 4, 2019. Public comments may be submitted by email to hope.richardson@dmas.virginia.gov or by postal mail or in person at following the address:

Virginia Department of Medical Assistance Services, FAMIS MOMS and FAMIS Select Demonstration Renewal, Attn: Hope Richardson, 600 East Broad Street, Richmond, VA 23219.

After considering public comments about the proposed demonstration renewal application, DMAS will make final decisions about the demonstration and submit a revised application to CMS. The summary of comments, as well as copies of written comments received, will be posted for public viewing on the DMAS website along with the demonstration extension application when it is submitted to CMS.

Information regarding the FAMIS MOMS and FAMIS Select demonstration renewal application can be found on the DMAS website at http://www.dmas.virginia.gov/#/hifawaiver. DMAS will update this website throughout the public comment and application process.

For more information about the FAMIS MOMS and FAMIS Select demonstration, which the Commonwealth is seeking to extend, please visit the CMS website at https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=8648.

Section 1115 of the Social Security Act gives the U.S. Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of Medicaid and the Children's Health Insurance Program (CHIP). Under this authority, the Secretary may waive certain provisions of Medicaid or CHIP to give states additional flexibility to design and improve their programs. To learn more about § 1115 demonstrations, please visit the CMS website at https://www.medicaid.gov/medicaid/section-1115-demo/index.html.

Contact Information: Hope Richardson, Policy Planning and Innovation, Department of Medical Assistance Services, 600 East Broad Street, Richmond, VA 23219, telephone (804) 786-7933, or email hope.richardson@dmas.virginia.gov.

STATE WATER CONTROL BOARD

Proposed Consent Order for Ariake U.S.A. Inc.

An enforcement action has been proposed for Ariake U.S.A. Inc. for violations at the Ariake U.S.A. Inc. food manufacturing facility in Harrisonburg, Virginia. The State Water Control Board proposes to issue a consent order with penalty to Ariake U.S.A. Inc. to address noncompliance with State Water Control Law. A description of the proposed action is available at the named Department of Environmental Quality office or online at www.deq.virginia.gov. Tiffany Severs will accept comments by email at tiffany.severs@deq.virginia.gov, FAX (540) 574-7878, or postal mail at Department of Environmental Quality, Valley Regional Office, 4411 Early Road, P.O. Box 3000, Harrisonburg, VA 22801, from March 4, 2019, to April 3, 2019.

Proposed Consent Order for Quality Built Homes Inc.

An enforcement action has been proposed for Quality Built Homes Inc. for violations of the State Water Control Law and regulations at the Oakwood Estates development located in King George County, Virginia. The State Water Control Board proposes to issue a consent order to resolve violations associated with the Oakwood Estates development. A description of the proposed action is available at the named Department of Environmental Quality office or online at www.deq.virginia.gov. Benjamin Holland will accept comments by email at benjamin.holland@deq.virginia.gov or postal mail at Department of Environmental Quality, Northern Regional Office, 13901 Crown Court, Woodbridge, VA 22193, from March 5, 2019, through April 4, 2019.

Notice of Community Meeting and Public Comment Period for Water Quality Study Total Maximum Daily Load for the Upper Bullpasture River

Community meeting: March 12, 2019, at 6 p.m. at the Stonewall Ruritan Hall, 67 Bullpasture River Road, McDowell, VA 24458.

Purpose of notice: The Department of Environmental Quality (DEQ) and its contractors, Virginia Tech Biological Systems Engineering Department, will present a draft water quality study known as a total maximum daily load (TMDL) for the Upper Bullpasture River and its tributaries in Highland County, Virginia. The river is listed on the § 303(d) TMDL Priority List and Report as impaired due to violations of Virginia's water quality standards for recreational use. This is an opportunity for local residents to learn about the condition of the river and provide input on the draft report. A public comment period will follow the meeting (March 13, 2019, through April 11, 2019). In the event of inclement weather, the meeting will be held on March 19, 2019, at the same time and location, and the public comment period will be extended accordingly.

Meeting description: A public informational meeting will be held to share a draft water quality study for the Upper Bullpasture River with the watershed community. This study was developed with input from local stakeholders, who were invited to provide information on potential sources of bacteria in the watershed and needed reductions through participation in a technical advisory committee. Section 303(d) of the Clean Water Act and § 62.1-44.19:7 C of the Code of Virginia require DEQ to develop TMDLs for pollutants responsible for each impaired water contained in Virginia's § 303(d) TMDL Priority List and Report. The meeting will be open to the public and all are welcome.

Description of study: The upper portion of the Bullpasture River, located in Highland County, Virginia is impaired for

the "recreational use" water quality standard, meaning that there is too much E. coli bacteria present in river. The impaired segment begins at the headwaters of the river at the Virginia-West Virginia border and extends to just below the confluence with Davis Run south of McDowell. Excessive bacteria levels may pose a threat to human health; therefore, a bacteria standard was established to preserve recreational uses in Virginia's waterbodies. This water quality study reports on the sources of bacteria and recommends reductions to meet a TMDL for the impaired segment of the river. A TMDL is the total amount of a pollutant a water body can contain and still meet water quality standards. To restore water quality in the Upper Bullpasture River, bacteria levels will need to be reduced to the TMDL amount. Through this process, Virginia agencies partnered with a technical advisory committee made up of local stakeholders, which met several times to identify sources of bacteria in the upper portion of the river and provided feedback on the reductions needed from these sources to meet the TMDL.

In addition to presenting the draft TMDL study to local stakeholders, the meeting will serve as an opportunity to solicit input on next steps in the water quality improvement process in the Bullpasture River. Initial plans for this effort included development of an implementation plan for the TMDL following completion of the study. The purpose of the implementation plan is to outline the actions necessary to meet the water quality improvement goals described in the study. Such a plan typically includes best management practices to reduce pollutant loading to the waterway, associated costs and benefits, a timeline for implementation, and education and outreach strategies to encourage participation. Completion of a TMDL implementation plan may open the door for additional technical assistance and cost share funding to support implementation actions in the watershed. Based on local input during TMDL development, interest in proceeding with an implementation plan for the TMDL in the Bullpasture River watershed has been limited. Since the TMDL process is largely voluntary, local support is critical to success. Thus, the public comment period for the draft TMDL study will also include an invitation for comments regarding appropriate next steps in the watershed, and more specifically, whether the process should be continued to include TMDL implementation plan development beginning in spring or summer 2019.

How to comment and participate: All meetings in support of TMDL development are open to the public and all interested parties are welcome. Written comments will be accepted through April 11, 2019, and should include the name, address, and telephone number of the person submitting the comments. For more information, or to submit written comments, please contact Nesha McRae, Department of Environmental Quality, Valley Regional Office, P.O. Box 3000, Harrisonburg, VA 22801, telephone (540) 574-7850, FAX (540) 574-7878, or email nesha.mcrae@deq.virginia.gov.

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.

ERRATA

BOARD OF LONG-TERM CARE ADMINISTRATORS

Title of Regulation: **18VAC95-20. Regulations Governing the Practice of Nursing Home Administrators.**

Publication: 35:12 VA.R. 1625-1635, February 4, 2019

Correction to Final Regulation:

Page 1629, 18VAC95-20-380 B 1, add "administrator" after "home"

VA.R. Doc. No. R17-4984; Filed February 12, 2019, 4:49 p.m.