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. **29:5 VA.R. 1075-1192 November 5, 2012,** refers to Volume 29, Issue 5, pages 1075 through 1192 of the *Virginia Register* issued on November 5, 2012.

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

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

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PUBLICATION SCHEDULE AND DEADLINES

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

December 2014 through December 2015

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

*Filing deadlines are Wednesdays unless otherwise specified.

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARD OF VETERINARY MEDICINE

Initial Agency Notice

Title of Regulation: **18VAC150-20. Regulations Governing the Practice of Veterinary Medicine.**

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

Name of Petitioner: Mark Finkler for the VVMA.

Nature of Petitioner's Request: To define the term "veterinary specialist" and prohibit its use unless the veterinarian is certified by an American Veterinary Medical Association-recognized specialty organization or an organization recognized by the American Board of Veterinary Specialists or any other board-approved organization.

Agency Plan for Disposition of Request: The petition will be published on December 29, 2014, in the Virginia Register of Regulations and also posted on the Virginia Regulatory Townhall at http://www.townhall.virginia.gov to receive public comment ending January 28, 2015. Following receipt of all comments on the petition to amend regulations, the board will decide whether to make any changes to the regulatory language. This matter will be on the board's agenda for its first meeting after the comment period, which is scheduled for February 19, 2015.

Public Comment Deadline: January 28, 2015.

Agency Contact: Elaine Yeatts, Agency Regulatory Coordinator, Department of Health Professions, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4688, or email elaine.yeatts@dhp.virginia.gov.

VA.R. Doc. No. R15-16; Filed December 1, 2014, 10:09 a.m

NOTICES OF INTENDED REGULATORY ACTION

TITLE 2. AGRICULTURE

BOARD OF AGRICULTURE AND CONSUMER SERVICES

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the Board of Agriculture and Consumer Services intends to consider amending **2VAC5-685, Regulations Governing Pesticide Applicator Certification under Authority of Virginia Pesticide Control Act**. The purpose of the proposed action is to amend certification requirements for pesticide applicators and clarify language to reflect current program practices. The amendments include (i) amending certain definitions; (ii) deleting the requirement that individuals who fail the certification examination must wait a prescribed number of days before retaking the examination; (iii) revising the process by which persons who cannot read or understand pesticide labels can be certified to apply restricted use pesticides on their own property; (iv) clarifying the on-the-job training requirements for prospective applicators; (v) establishing numeric identifiers for the existing categories of private applicator certification; (vi) prescribing the minimum requirements for board-approved recertification training programs; and (vii) clarifying the requirements for the issuance of a certificate pursuant to a reciprocal agreement with another state. The proposed action is intended to ensure the competence of pesticide applicators through consistent standards of training, testing, and certification.

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

Statutory Authority: § 3.2-3906 of the Code of Virginia.

Public Comment Deadline: January 28, 2015.

Agency Contact: Andres Alvarez, Director, Division of Consumer Protection, Department of Agriculture and Consumer Services, P.O. Box 1163, Richmond, VA 23218, telephone (804) 225-3821, FAX (804) 371-7479, TTY (800) 828-1120, or email andres.alvarez@vdacs.virginia.gov.

VA.R. Doc. No. R15-4126; Filed December 10, 2014, 11:43 a.m.

◆ ◆

TITLE 12. HEALTH

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL 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 Behavioral Health and Developmental Services intends to consider promulgating **12VAC35-225, Requirements for Virginia's Early Intervention System**. The purpose of the proposed action is to promulgate regulations to codify those portions of Virginia's policies, procedures, and practices that require the force of law to ensure that Virginia remains in compliance with federal mandates, including (i) details regarding the state infrastructure for early intervention services not already provided by the Code of Virginia; (ii) clarifying Virginia's referral system; (iii) outlining the intake, eligibility determination, and assessment processes; (iv) detailing the expectations regarding service planning and delivery, including transition or discharge from the early intervention system of care; (v) explaining the service funding and payment expectations; (vi) establishing the procedural safeguards that individuals can expect; (vii) addressing the alternative to resolve disputes; and (viii) establishing a certification process for certain early intervention practitioners and a comprehensive system of personnel development.

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

Statutory Authority: § 2.2-5304 of the Code of Virginia; 34 CFR Part 303.

Public Comment Deadline: February 11, 2015.

Agency Contact: Catherine Hancock, Part C Administrator, Department of Behavioral Health and Developmental Services, 1220 Bank Street, Richmond, VA 23218, telephone (804) 371-6592, FAX (804) 371-7959, or email catherine.hancock@dbhds.virginia.gov.

VA.R. Doc. No. R15-3889; Filed December 15, 2014, 2:51 p.m.

◆ ◆

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARD OF AUDIOLOGY AND SPEECH-LANGUAGE PATHOLOGY

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the Board of Audiology and Speech-Language Pathology intends to consider amending **18VAC30-20, Regulations Governing the Practice of Audiology and Speech-Language Pathology**. Chapter 661 of the 2014 Acts of Assembly authorizes a person who has met the qualifications prescribed by the board to practice as an assistant speech-language pathologist under the supervision of a licensed speech-language pathologist. The purpose of the proposed regulatory action is to set out the qualifications for such a person, the scope of his practice, and the responsibilities of the licensed supervisor.

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

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

Public Comment Deadline: January 28, 2015.

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

VA.R. Doc. No. R15-4179; Filed December 10, 2014, 10:50 a.m.

REGULATIONS

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

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

TITLE 2. AGRICULTURE

BOARD OF AGRICULTURE AND CONSUMER SERVICES

Final Regulation

Title of Regulation: **2VAC5-317. Regulations for the Enforcement of the Noxious Weed Law (adding 2VAC5-317-10 through 2VAC5-317-100).**

Statutory Authority: § 3.2-802 of the Code of Virginia.

Effective Date: January 29, 2015.

Agency Contact: Andres Alvarez, Director, Division of Consumer Protection, Department of Agriculture and Consumer Services, P.O. Box 1163, Richmond, VA 23218, telephone (804) 225-3821, FAX (804) 371-7479, TTY (800) 828-1120, or email andres.alvarez@vdacs.virginia.gov.

Summary:

The regulation (i) establishes a two-tier list of plants deemed by the Board of Agriculture and Consumer Services to be noxious weeds, (ii) prohibits the movement of noxious weeds or articles capable of transporting noxious weeds into or within the Commonwealth, (iii) identifies eradication activities for certain noxious weeds, and (iv) establishes the Noxious Weeds Advisory Committee.

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

CHAPTER 317
REGULATIONS FOR THE ENFORCEMENT OF THE NOXIOUS WEEDS LAW

2VAC5-317-10. Definitions.

The following words and terms shall have the following meanings unless the context clearly indicates otherwise:

"Board" means the Virginia Board of Agriculture and Consumer Services.

"Business day" means a day that is not a Saturday, Sunday, or legal holiday, or a day on which state government offices are closed.

"Certificate" means a document issued by an inspector or by a person operating in accordance with a compliance agreement to allow the movement of regulated articles to any destination.

"Commissioner" means the Commissioner of the Virginia Department of Agriculture and Consumer Services.

["Committee" means the Noxious Weeds Advisory Committee established pursuant to 2VAC5-317-100.]

"Compliance agreement" means a written agreement between a person engaged in handling, receiving, or moving regulated articles and the Virginia Department of Agriculture and Consumer Services or the United States Department of Agriculture, or both, wherein the former agrees to fulfill the requirements of the compliance agreement and comply with the provisions of this chapter.

"Consignee" means any person to whom any regulated article is shipped for handling, sale, resale, or any other purpose.

"Department" means the Virginia Department of Agriculture and Consumer Services.

"Infested" or "infestation" means the presence of a listed noxious weed or the existence of circumstances that make it reasonable to believe that life stages of a listed noxious weed are present.

"Inspector" means an employee of the Virginia Department of Agriculture and Consumer Services or other person authorized by the Commissioner of the Virginia Department of Agriculture and Consumer Services to enforce the provisions of this chapter.

"Limited permit" means a document issued by an inspector to allow the movement of regulated articles to a specific destination.

"Listed noxious weed" means any plant listed in this chapter as either a Tier 1 or Tier 2 noxious weed.

"Move," "moved," or "movement" means shipped, offered for shipment, received for transportation, transported, carried, or allowed to be moved, shipped, transported, or carried.

"Noxious weed" means the term as defined in § 3.2-800 of the Code of Virginia.

"Noxious Weeds Law" means the statute set forth in [Chapter 8 ( ] § 3.2-800 et seq. [ )] of [Title 3.2 of] the Code of Virginia.

"Person" means the term as defined in § 1-230 of the Code of Virginia.

"Regulated article" means any listed noxious weed or any article or means of conveyance known to be infested or determined by an inspector to present a risk of spreading a listed noxious weed.

"Tier 1 noxious weed" means any noxious weed that is not native to the Commonwealth that (i) has no known populations present in the Commonwealth or (ii) is not

widely disseminated in the Commonwealth and for which successful eradication or suppression is likely.

"Tier 2 noxious weed" means any noxious weed that (i) is not native to the Commonwealth, (ii) is not widely disseminated in the Commonwealth, and (iii) for which successful suppression is feasible but eradication is unlikely.

"Waybill" means a document containing the details of a shipment of goods.

2VAC5-317-20. Tier 1 and Tier 2 noxious weeds.

A. The following plants are hereby declared Tier 1 noxious weeds:

1. Vitex rotundifolia, Beach vitex.

2. Salvinia molesta, Giant salvinia.

3. Solanum viarum, Tropical soda apple.

4. Heracleum mantegazzianum, Giant hogweed.

5. Oplismenus hirtellus spp. undulatifolius, Wavyleaf basketgrass.

B. The following plants are hereby declared Tier 2 noxious weeds:

1. Imperata cylindrica, Cogon grass. [~~The cultivar Imperata cylindrica "Red Baron" (Japanese blood grass) is not subject to the provisions of this chapter.~~]

2. Lythrum salicaria, Purple loosestrife.

3. Ipomoea aquatica, Water spinach.

2VAC5-317-30. Conditions governing the intrastate movement of regulated articles.

The movement of a regulated article is prohibited unless accompanied by a valid certificate or limited permit.

2VAC5-317-40. Issuance and cancellation of certificates and limited permits.

A. A certificate or a limited permit may be issued by an inspector for the movement of a regulated article into, within, or out of the Commonwealth when the regulated article meets the following three conditions:

1. The regulated article is to be moved:

a. Intrastate to a specified destination under conditions that specify the limited handling, utilization, processing, or treatment of the article when the inspector determines that such movement will not result in the spread of the noxious weed; or

b. By a state or federal agency, or person authorized by the department, for experimental or scientific purposes;

2. The regulated article is to be moved in compliance with all additional conditions deemed necessary under the Noxious Weeds Law to prevent the spread of the noxious weed; and

3. The regulated article is eligible for unrestricted movement under all other domestic plant quarantines and regulations applicable to the regulated article.

B. Any certificate or limited permit that has been issued or authorized may be withdrawn by the inspector orally or in writing if the inspector determines that the holder of the certificate or limited permit has not complied with all conditions for the use of the certificate or limited permit, or with any applicable compliance agreement. If the withdrawal is oral, the withdrawal and the reasons for the withdrawal shall be confirmed in writing and communicated to the certificate or limited permit holder as promptly as circumstances allow.

2VAC5-317-50. Assembly and inspection of regulated articles.

A. Any person who desires to move a regulated article and who is required to have a limited permit for such movement shall apply for a limited permit as far in advance as practical but no fewer than five business days before the regulated article is to be moved.

B. The regulated article must be assembled at the place and in the manner the inspector designates as necessary to facilitate inspection and shall be safeguarded to prevent infestation.

2VAC5-317-60. Attachment and disposition of certificates and limited permits.

A. A certificate or limited permit required for the movement of a regulated article into, within, or out of the Commonwealth must be attached at all times during the intrastate movement to the outside of the container that contains the regulated article or to the regulated article itself. The requirements of this section may also be met by attaching the certificate or limited permit to the consignee's copy of the waybill, provided the regulated article is sufficiently described on the certificate or limited permit and on the waybill to facilitate the identification of the regulated article.

B. The certificate or limited permit for the intrastate movement of a regulated article must be furnished by the carrier to the consignee at the destination of the regulated article. A copy of the certificate or the limited permit must be retained by the sender of the regulated article at the place of shipment.

2VAC5-317-70. Inspection and disposal of regulated articles.

Upon presentation of official credentials, an inspector is authorized to stop and inspect and to seize, destroy, or otherwise dispose of or require disposal of regulated articles in accordance with the provisions of the Noxious Weeds Law.

2VAC5-317-80. Eradication and suppression activities for Tier 1 noxious weeds.

The commissioner may conduct eradication or suppression activities to prevent the dissemination of a Tier 1 noxious weed. Eradication or suppression activities may include, but are not limited to, the following: destruction, seizure, stop sale, stop delivery, treatment, or ordering the regulated article to be returned to its point of origin.

2VAC5-317-90. Nonliability of the department.

The department shall not be liable for costs incurred by third parties resulting from, or incidental to, inspections required under the provisions of this chapter.

2VAC5-317-100. Noxious Weeds Advisory Committee.

[~~The commissioner shall convene an annual meeting of the Noxious Weeds Advisory Committee. The committee shall advise the commissioner on those plants that the commissioner, at his discretion, may present to the board for declaration or delisting as noxious weeds.~~

A. The commissioner shall establish a Noxious Weeds Advisory Committee for the purpose of assisting the department in the evaluation and risk-assessment of plants that may be declared noxious weeds in 2VAC5-317-20. The committee may also consider the delisting of plants that were previously declared noxious weeds.

B. The committee shall present recommendations to the commissioner regarding the listing or delisting of plants as noxious weeds. The committee shall consider the protection of Virginia's natural resources and the environment, as well as the economic impact on nurseries, landscapers, agricultural producers, and other affected industries in the formulation of its recommendations.

C. The commissioner shall convene a meeting of the committee at least once annually, and may convene additional meetings at his discretion. Department staff will coordinate the scheduling and logistics of the meetings, including the posting of meeting notices on the Commonwealth Calendar.

D. Committee members shall serve at the invitation of the commissioner. For every meeting of the committee, the commissioner shall invite representatives of Virginia's agricultural, horticultural, and environmental industries as well as representatives of Virginia's land grant universities and relevant executive branch agencies, to include but not be limited to:

1. A conservation representative or organization,
2. An agribusiness representative or organization,
3. A local government representative or organization,
4. Virginia Cooperative Extension,
5. Virginia Department of Conservation and Recreation,
6. Virginia Department of Forestry,
7. Virginia Department of Game and Inland Fisheries,
8. Virginia Department of Transportation,
9. A farming representative or organization,
10. A forage-based agriculture representative or organization,
11. A native plant conservation representative or organization,
12. A nursery and landscaping representative or organization,
13. Virginia Polytechnic Institute and State University, and
14. Virginia State University.

E. The commissioner may invite representatives of local government agencies from localities where a plant of concern has been found or from localities that could be impacted by the declaration of a plant as a noxious weed. The commissioner may invite representatives of other organizations not listed in subsection D of this section that may have a direct interest in the declaration of a plant as a noxious weed.

F. Prior to each meeting of the committee, the commissioner or his designee shall make timely notification to committee members of any plant that the department is considering for possible listing or delisting as a noxious weed. The notification will include the scientific data and rationale for such listing or delisting. The commissioner or his designee shall survey committee members to determine if any member has identified a plant that should be considered for possible listing or delisting as a noxious weed. Any committee member who has identified a plant that should be considered for possible listing or delisting as a noxious weed shall provide department staff with relevant scientific data and the rationale to support the listing or delisting of the plant. The commissioner or his designee will distribute the scientific data and rationale to other committee members for their review and consideration prior to the meeting of the committee.

G. The committee, by majority vote of members, may develop and present to the commissioner a list of plants recommended for listing or delisting as noxious weeds.

H. The commissioner shall consider the recommendations of the committee in his preparation of the list of plants that he presents to the board for listing or delisting as noxious weeds.

I. If a regulatory action to list or delist a noxious weed is under way, the commissioner may delay the pursuit of a new regulatory action to list or delist a new noxious weed until the current action is completed.]

VA.R. Doc. No. R12-2814; Filed December 10, 2014, 11:52 a.m.

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TITLE 4. CONSERVATION AND NATURAL RESOURCES

BOARD OF GAME AND INLAND FISHERIES

Final Regulation

REGISTRAR'S NOTICE: The Board of Game and Inland Fisheries is claiming an exemption from the Administrative Process Act pursuant to § 2.2-4002 A 3 of the Code of Virginia when promulgating regulations regarding the management of wildlife.

Title of Regulation: **4VAC15-20. Definitions and Miscellaneous: In General (amending 4VAC15-20-50).**

Statutory Authority: §§ 29.1-103, 29.1-501, and 29.1-502 of the Code of Virginia.

Effective Date: January 1, 2015.

Agency Contact: Phil Smith, Regulatory Coordinator, Department of Game and Inland Fisheries, 4010 West Broad Street, Richmond, VA 23230, telephone (804) 367-8341 or email phil.smith@dgif.virginia.gov.

Summary:

The amendments (i) update the referenced year of the department's "List of Native and Naturalized Fauna of Virginia" and (ii) exempt from the definition of domestic animals those swine that are free-roaming or wild.

4VAC15-20-50. Definitions; "wild animal," "native animal," "naturalized animal," "nonnative (exotic) animal," and "domestic animal."

In accordance with § 29.1-100 of the Code of Virginia, the following terms shall have the meanings ascribed to them by this section when used in regulations of the board:

"Native animal" means those species and subspecies of animals naturally occurring in Virginia, as included in the department's ~~2012~~ 2014 "List of Native and Naturalized Fauna of Virginia," with copies available in the Richmond and regional offices of the department.

"Naturalized animal" means those species and subspecies of animals not originally native to Virginia ~~which~~ that have established wild, self-sustaining populations, as included in the department's ~~2012~~ 2014 "List of Native and Naturalized Fauna of Virginia," with copies available in the Richmond and regional offices of the department.

"Nonnative (exotic) animal" means those species and subspecies of animals not naturally occurring in Virginia, excluding domestic and naturalized species.

The following animals are defined as domestic animals:

Domestic dog (Canis familiaris), including wolf hybrids.

Domestic cat (Felis catus), including hybrids with wild felines.

Domestic horse (Equus caballus), including hybrids with Equus asinus.

Domestic ass, burro, and donkey (Equus asinus).

Domestic cattle (Bos taurus and Bos indicus).

Domestic sheep (Ovis aries) including hybrids with wild sheep.

Domestic goat (Capra hircus).

Domestic swine (Sus scrofa domestica), including pot-bellied pig excluding any swine that are free-roaming or wild.

Llama (Lama glama).

Alpaca (Lama pacos).

Camels (Camelus bactrianus and Camelus dromedarius).

Domesticated races of hamsters (Mesocricetus spp.).

Domesticated races of mink (Mustela vison) where adults are heavier than 1.15 kilograms or their coat color can be distinguished from wild mink.

Domesticated races of red fox (Vulpes) where their coat color can be distinguished from wild red fox.

Domesticated races of guinea pigs (Cavia porcellus).

Domesticated races of gerbils (Meriones unguiculatus).

Domesticated races of chinchillas (Chinchilla laniger).

Domesticated races of rats (Rattus norvegicus and Rattus rattus).

Domesticated races of mice (Mus musculus).

Domesticated races of European rabbit (Oryctolagus cuniculus).

Domesticated races of chickens (Gallus).

Domesticated races of turkeys (Meleagris gallopavo).

Domesticated races of ducks and geese distinguishable morphologically from wild birds.

Feral pigeons (Columba domestica and Columba livia) and domesticated races of pigeons.

Domesticated races of guinea fowl (Numida meleagris).

Domesticated races of peafowl (Pavo cristatus).

"Wild animal" means any member of the animal kingdom, except domestic animals, including without limitation any native, naturalized, or nonnative (exotic) mammal, fish, bird, amphibian, reptile, mollusk, crustacean, arthropod or other invertebrate, and includes any hybrid of them, except as otherwise specified in regulations of the board, or part, product, egg, or offspring of them, or the dead body or parts of them.

VA.R. Doc. No. R14-4050; Filed December 10, 2014, 9:33 a.m.

Final Regulation

Title of Regulation: **4VAC15-30. Definitions and Miscellaneous: Importation, Possession, Sale, Etc., of Animals (amending 4VAC15-30-10).**

Statutory Authority: §§ 29.1-103, 29.1-501, and 29.1-502 of the Code of Virginia.

Effective Date: January 1, 2015.

Agency Contact: Phil Smith, Regulatory Coordinator, Department of Game and Inland Fisheries, 4010 West Broad Street, Richmond, VA 23230, telephone (804) 367-8341 or email phil.smith@dgif.virginia.gov.

Summary:

The amendment prohibits marking fish with fish tagging equipment for personal information or research by prohibiting the conducting of research on any wild animal unless otherwise specifically permitted by law or regulation.

4VAC15-30-10. Possession, importation, sale, etc., of wild animals.

Under the authority of §§ 29.1-103 and 29.1-521 of the Code of Virginia it shall be unlawful to take, possess, conduct research, import, cause to be imported, export, cause to be exported, buy, sell, offer for sale, or liberate within the Commonwealth any wild animal unless otherwise specifically permitted by law or regulation. Unless otherwise stated, for the purposes of identifying species regulated by the board, when both the scientific and common names are listed, the scientific reference to genus and species will take precedence over common names.

VA.R. Doc. No. R14-4051; Filed December 10, 2014, 10:32 a.m.

Final Regulation

Title of Regulation: **4VAC15-320. Fish: Fishing Generally (amending 4VAC15-320-25, 4VAC15-320-60, 4VAC15-320-120).**

Statutory Authority: §§ 29.1-103, 29.1-501, and 29.1-502 of the Code of Virginia.

Effective Date: January 1, 2015.

Agency Contact: Phil Smith, Regulatory Coordinator, Department of Game and Inland Fisheries, 4010 West Broad Street, Richmond, VA 23230, telephone (804) 367-8341 or email phil.smith@dgif.virginia.gov.

Summary:

The amendments (i) adjust or establish the freshwater fishing creel (i.e., possession) and length limits that are allowable in various waters of the state; (ii) add Clinch Mountain and Crooked Creek fee fishing areas to the list of those areas in which children 12 years and younger may fish without a permit if under the direct supervision of a permitted adult, with the daily creel limit for both adult and child or children combined to be six trout; and (iii) prohibit stocking blue catfish and their hybrids into privately owned ponds and lakes.

4VAC15-320-25. Creel and length limits.

The creel limits (including live possession) and the length limits for the various species of fish shall be as follows, unless otherwise excepted by posted rules at department-owned or department-controlled waters (see 4VAC15-320-100 D).

Type of fish	Subtype or location	Creel and length limits	Geographic exceptions	Creel or length limits for exceptions
largemouth bass, smallmouth bass, spotted bass		5 per day in the aggregate (combined); No statewide length limits	**Lakes**	
			Briery Creek Lake	No bass 16 to 24 inches, only 1 per day longer than 24 inches
			Buggs Island (Kerr)	Only 2 of 5 bass less than 14 inches
			Claytor Lake	No bass less than 12 inches
			Flannagan Reservoir	No bass less than 12 inches
			Lake Gaston	Only 2 of 5 bass less than 14 inches
			Leesville Reservoir	Only 2 of 5 bass less than 14 inches
			Lake Moomaw	No bass less than 12 inches
			Philpott Reservoir	No bass less than 12 inches
			Quantico Marine Base waters	No bass 12 to 15 inches
			Smith Mt. Lake and its tributaries below Niagara Dam	Only 2 of 5 bass less than 14 inches

			Rivers	
			Clinch River – within the boundaries of Scott, Wise, Russell, or Tazewell counties	No bass ~~11 to 14 inches~~ less than 20 inches, only 1 bass per day longer than 20 inches
			Dan River and tributaries ~~down stream~~ downstream from the Union Street Dam, Danville	Only 2 of 5 bass less than 14 inches
			James River – Confluence of the Jackson and Cowpasture rivers (Botetourt County) downstream to the 14th Street Bridge in Richmond	No bass 14 to 22 inches, only 1 per day longer than 22 inches
			New River – Fields Dam (Grayson County) downstream to the VA – WV state line and its ~~tributary~~ tributaries Little River downstream from Little River Dam in Montgomery County, Big Walker Creek from the Norfolk and Western Railroad Bridge downstream to the New River, and Wolf Creek from the Narrows dam downstream to the New River in Giles County (This does not include Claytor Lake, which is delineated as: The upper end of the island at Allisonia downstream to the dam)	No bass 14 to ~~20~~ 22 inches, only 1 per day longer than ~~20~~ 22 inches
			North Fork Holston River - Rt. 91 bridge upstream of Saltville, VA downstream to the VA-TN state line	No bass less than 20 inches, only 1 per day longer than 20 inches

			North Fork Shenandoah River – Rt. 42 bridge, Rockingham Co. downstream to the confluence with S. Fork Shenandoah at Front Royal	No bass 11 to 14 inches
			Potomac River - Virginia tidal tributaries above Rt. 301 bridge	No bass less than 15 inches from March 1 through June 15
			Roanoke (Staunton) River - and its tributaries below Difficult Creek, Charlotte Co.	Only 2 of 5 bass less than 14 inches
			Shenandoah River –	
			Confluence of South Fork and North Fork rivers, Front Royal, downstream, to the Warren Dam, near Front Royal	No bass 11 to 14 inches
			Base of Warren Dam, near Front Royal downstream to Rt. 17/50 bridge	No bass 14 to 20 inches, only 1 per day longer than 20 inches
			Rt. 17/50 bridge downstream to VA - WV state line	No bass 11 to 14 inches
			South Fork Shenandoah River -	
			Confluence of North and South rivers, below Port Republic, downstream to Shenandoah Dam, near Town of Shenandoah	No bass 11 to 14 inches
			Base of Shenandoah Dam, near Town of Shenandoah, downstream to Luray Dam, near Luray	No bass 14 to 20 inches, only 1 per day longer than 20 inches

			Base of Luray Dam, near Luray, downstream to the confluence with North Fork of Shenandoah, Front Royal	No bass 11 to 14 inches
			Staunton River - Leesville Dam (Campbell County) downstream to the mouth of Difficult Creek, Charlotte County	No smallmouth bass less than 20 inches, only 1 per day longer than 20 inches
striped bass	landlocked striped bass and landlocked striped bass x white bass hybrids	4 per day in the aggregate; No fish less than 20 inches	Buggs Island (Kerr) reservoir including the Staunton River to Leesville Dam and the Dan River to Union Street Dam (Danville)	October 1 - May 31: 2 per day in the aggregate; No striped bass or hybrid striped bass less than 24 inches; June 1 - September 30: 4 per day in the aggregate; No length limit
			Smith Mountain Lake and its tributaries, including the Roanoke River upstream to Niagara Dam	2 per day in the aggregate; November 1 - May 31: No striped bass ~~26~~ 30 to ~~36~~ 40 inches; June 1 - October 31: No length limit
			Lake Gaston	4 per day in the aggregate October 1 - May 31: No striped bass or hybrid striped bass less than 20 inches June 1 - September 30: No length limit

	anadromous (coastal) striped bass above the fall line in all coastal rivers of the Chesapeake Bay	Creel and length limits shall be set by the Virginia Marine Resources Commission for recreational fishing in tidal waters		
	anadromous (coastal) in the Meherrin, Nottoway, Blackwater (Chowan Drainage), North Landing and Northwest Rivers and their tributaries plus Back Bay	2 per day; No striped bass less than 18 inches		
white bass		5 per day; No statewide length limits		
walleye		5 per day in the aggregate; No walleye or saugeye less than 18 inches	New River upstream of Buck Dam in Carroll County	No walleye less than 20 inches
			Claytor Lake and the New River upstream of Claytor Lake Dam to Buck Dam in Carroll County	February 1 - May 31: 2 walleye per day; no walleye 19 to 28 inches; June 1 - January 31: 5 walleye per day; no walleye less than 20 inches
sauger		2 per day; No statewide length limits		
yellow perch		No statewide daily limit; No statewide length limits	Lake Moomaw	10 per day
chain pickerel		5 per day; No statewide length limits	Gaston and Buggs Island (Kerr) reservoirs	No daily limit

northern pike		2 per day; No pike less than 20 inches		
muskellunge		2 per day; No muskellunge less than 30 inches	New River - Fields Dam (Grayson County) downstream to the VA - WV state line, including Claytor Lake	1 per day No muskellunge less than 42 inches
bluegill (bream) and other sunfish excluding crappie, rock bass (redeye) and Roanoke bass		50 per day in the aggregate; No statewide length limits	Gaston and Buggs Island (Kerr) reservoirs and that portion of the New River from the VA - NC state line downstream to the confluence of the New and Little Rivers in Grayson County	No daily limit
crappie (black or white)		25 per day in the aggregate; No statewide length limits	Gaston and Buggs Island (Kerr) reservoirs and that portion of the New River from the VA - NC state line downstream to the confluence of the New and Little Rivers in Grayson County	No daily limit
			Flannagan and South Holston reservoirs	No crappie less than 10 inches
rock bass (redeye)		25 per day; No statewide length limits	Gaston and Buggs Island (Kerr) reservoirs and that portion of the New River from the VA - NC state line downstream to the confluence of the New and Little Rivers in Grayson County.	No daily limit
			Nottoway and Meherrin rivers and their tributaries	5 per day in the aggregate with Roanoke bass; No rock bass less than 8 inches

Roanoke bass		No statewide daily limit; No statewide length limits	Nottoway and Meherrin rivers and their tributaries	5 per day in the aggregate with rock bass; No Roanoke bass less than 8 inches
trout	See 4VAC15-330. Fish: Trout Fishing.			
catfish	channel, white, and flathead catfish	20 per day; No length limits	All rivers below the fall line	No daily limit
	blue catfish	20 per day, only 1 blue catfish per day longer than 32 inches	All rivers below the fall line	No daily limit, except only 1 blue catfish per day longer than 32 inches
	yellow, brown, and black bullheads	No daily limit; No length limits		
American shad and hickory shad	James River above the fall line (14th Street Bridge), the Meherrin River above Emporia Dam, the Chickahominy River above Walkers Dam, the Appomattox River above Harvell Dam, the Pamunkey River and the Mattaponi River above the Rt. 360 bridge, and the Rappahannock River above the Rt. 1 bridge, and Virginia waters of Lake Gaston and Buggs Island (Kerr) Reservoir and tributaries to include the Dan and Staunton rivers	No possession (catch and release only)		
	~~(below the fall line) in tidal~~ Above and below the fall line in all coastal rivers of the Chesapeake Bay	Creel and length limits shall be the same as those set by the Virginia Marine Resources Commission for these species in tidal rivers		

	Meherrin River below Emporia Dam Nottoway River, Blackwater River (Chowan Drainage), North Landing and Northwest rivers, and their tributaries plus Back Bay	10 per day in the aggregate No length limits		
anadromous (coastal) alewife and blueback herring	Above and below the fall line in all coastal rivers of the Chesapeake Bay	Creel and length limits shall be the same as those set by the Virginia Marine Resources Commission for these species in tidal rivers		
	Meherrin River, Nottoway River, Blackwater River (Chowan Drainage), North Landing and Northwest rivers, and their tributaries plus Back Bay	No possession		
red drum	Back Bay and tributaries including Lake Tecumseh and the North Landing River and its tributaries	1 per day; No drum less than 18 inches or greater than 27 inches		
spotted sea trout (speckled trout)	Back Bay and tributaries including Lake Tecumseh and the North Landing River and its tributaries	4 per day; No sea trout less than 14 inches		
grey trout (weakfish)	Back Bay and tributaries including Lake Tecumseh and North Landing River and its tributaries	1 per day; No grey trout less than 12 inches		
southern flounder	Back Bay and tributaries including Lake Tecumseh and the North Landing River and its tributaries	6 per day; No flounder less than 15 inches		

northern snakehead		Anglers may possess snakeheads taken from Virginia waters if they immediately kill the fish and notify the headquarters or a regional office of the department; notification may be made by telephoning (804) 367-2925 No statewide daily limit No statewide length limits		
other native or naturalized nongame fish	See 4VAC15-360-10. Fish: Aquatic Invertebrates, Amphibians, Reptiles, and Nongame Fish. Taking aquatic invertebrates, amphibians, reptiles and nongame fish for private use.			
endangered or threatened fish	See 4VAC15-20-130. Definitions and Miscellaneous: In General. Endangered and threatened species; adoption of federal list; additional species enumerated.			
nonnative (exotic) fish	See 4VAC15-30-40. Definitions and Miscellaneous: Importation, Possession, Sale, Etc., of Animals. Importation requirements, possession and sale of nonnative (exotic) animals.			

4VAC15-320-60. Approval required to stock fish into inland waters.

It shall be unlawful to stock any species of fish into any inland waters of the Commonwealth, without first obtaining written approval to do so from the department. Nothing in this section shall be construed as restricting the use of native and naturalized species of fish in privately-owned ponds and lakes, except blue catfish and their hybrids may not be stocked.

4VAC15-320-120. Special daily permit for fishing in Clinch Mountain Wildlife Management Area, Douthat State Park Lake and Crooked and Wilson Creeks.

It shall be unlawful to fish in the Clinch Mountain Wildlife Management Area (except in Little Tumbling Creek and Laurel Bed Lake), in Douthat State Park Lake and in Wilson Creek both above the lake to the park boundary and downstream to the lower USFS boundary, and in the Crooked Creek fee fishing area in Carroll County without having first paid to the department for such privilege a daily use fee. Such daily use fee shall be in addition to all other license fees provided by law. Upon payment of the daily use fee the department shall issue a special permit ~~which~~ that shall be signed and carried by the person fishing. This fee will be required from the first Saturday in April through September 30 at Clinch Mountain Wildlife Management Area (except Little Tumbling Creek and Laurel Bed Lake) and at Crooked Creek fee fishing area in Carroll County, and from the first Saturday in April through June 15 and from September 15 through October 31 at Douthat State Park Lake and Wilson Creek, except that the director may temporarily suspend fee requirements if conditions cause suspension of trout stocking. During the remainder of the year, these waters will revert to designated stocked trout waters and a trout license will be required except as provided in 4VAC15-20-190. No fishing is permitted in these waters for five days preceding the opening day. Fishing shall begin at 9 a.m. on opening day at all fee areas. After opening day, fishing times will be as posted at each fee area. The department may recognize clearly marked "children only" fishing areas within any department fee fishing area. Within these "children only" areas, children 12 years old or ~~less~~ younger may fish without the daily use fee if accompanied by a fully licensed adult who has purchased a valid daily permit. No person ~~over~~ older than 12 years of age may fish in these children-only areas. Also, children 12 years of age and ~~under~~ younger can fish without a permit in ~~the entire Douthat Fee Fishing Area~~ all three fee fishing areas if under the direct supervision of a permitted adult. However, the combined daily creel limit for both adult and child/children in such a party shall not exceed six trout. During the fee fishing season these waters will be subject to 4VAC15-330-60, 4VAC15-330-80, and 4VAC15-330-90, as it relates to designated stocked trout waters.

4VAC15-320-150. [Shooting certain fish in Clinch River in Scott County. ~~(Repealed.)~~

It shall be lawful for any person holding a current license to fish to shoot suckers, redhorse and carp with a rifle, during the hours of sunrise to sunset, from April 15 to May 31, both inclusive, in the waters of the Clinch River within the limits of Scott County; except, that it shall be unlawful to shoot fish on Sunday, or within the limits of any town, or from any

bridge. No more than 20 such fish may be so taken during any one day. All persons engaged in the shooting or the retrieval of fish pursuant to this section shall have in their possession a current fishing license.]

VA.R. Doc. No. R14-4052; Filed December 10, 2014, 11:15 a.m.

Final Regulation

Title of Regulation: **4VAC15-330. Fish: Trout Fishing (amending 4VAC15-330-150).**

Statutory Authority: §§ 29.1-103, 29.1-501, and 29.1-502 of the Code of Virginia.

Effective Date: January 1, 2015.

Agency Contact: Phil Smith, Regulatory Coordinator, Department of Game and Inland Fisheries, 4010 West Broad Street, Richmond, VA 23230, telephone (804) 367-8341 or email phil.smith@dgif.virginia.gov.

Summary:

The amendments add certain sections of streams to the list of catch and release trout stream waters in which it is lawful to fish for trout using only artificial lures with single hooks year-round.

4VAC15-330-150. Special provision applicable to Stewarts Creek Trout Management Area; certain portions of the Dan, Rapidan, South Fork Holston and Staunton rivers, the Brumley Creek, East Fork of Chestnut Creek, Little Stony Creek, Little Tumbling Creek, North Creek, Roaring Fork, ~~North Creek,~~ Spring Run, Stony Creek, Venrick Run, ~~Brumley Creek,~~ and their tributaries.

It shall be lawful year around to fish for trout using only artificial lures with single hooks within ~~the~~:

1. The Stewarts Creek Trout Management Area in Carroll County~~, in the~~.

2. The Rapidan and Staunton rivers and their tributaries upstream from a sign at the Lower Shenandoah National Park boundary in Madison County~~, in the~~.

3. The Dan River and its tributaries between the Townes Dam and the Pinnacles Hydroelectric Project powerhouse in Patrick County~~, in the~~.

4. The East Fork of Chestnut Creek (Farmer's Creek) and its tributaries upstream from the Blue Ridge Parkway in Grayson and Carroll Counties~~, in~~.

5. Roaring Fork and its tributaries upstream from the southwest boundary of Beartown Wilderness Area in Tazewell County ~~and in that~~.

6. That section of the South Fork Holston River and its tributaries from the concrete dam at Buller Fish Culture Station downstream to the lower boundary of the Buller Fish Culture Station in Smyth County~~, and in~~.

7. North Creek and its tributaries upstream from a sign at the George Washington National Forest North Creek Campground in Botetourt County~~, in~~.

8. Spring Run from it confluence with Cowpasture River upstream to a posted sign at the discharge for Coursey Springs Hatchery in Bath County~~, in~~.

9. Venrick Run and its tributaries within the Big Survey Wildlife Management Area and Town of Wytheville property in Wythe County~~, and in~~.

10. Brumley Creek and its tributaries from the Hidden Valley Wildlife Management Area boundary upstream to the Hidden Valley Lake Dam in Washington County.

11. Stony Creek (Mountain Fork) and its tributaries within the Jefferson National Forest in Wise and Scott Counties from the outlet of High Knob Lake downstream to the confluence of Chimney Rock Fork and Stony Creek.

12. Little Stony Creek and its tributaries within the Jefferson National Forest in Scott County from the Falls of Little Stony Creek downstream to a posted sign at the Hanging Rock Recreation Area.

13. Little Tumbling Creek and its tributaries within the Clinch Mountain Wildlife Management Area in Smyth and Tazewell Counties downstream to the concrete bridge.

All trout caught in these waters must be immediately returned to the water. No trout or bait may be in possession at any time in these areas.

VA.R. Doc. No. R14-4053; Filed December 10, 2014, 8:56 a.m.

Final Regulation

Title of Regulation: **4VAC15-340. Fish: Seines and Nets (amending 4VAC15-340-40, 4VAC15-340-60).**

Statutory Authority: §§ 29.1-103, 29.1-501, and 29.1-502 of the Code of Virginia.

Effective Date: January 1, 2015.

Agency Contact: Phil Smith, Regulatory Coordinator, Department of Game and Inland Fisheries, 4010 West Broad Street, Richmond, VA 23230, telephone (804) 367-8341 or email phil.smith@dgif.virginia.gov.

Summary:

The amendments prohibit the use of seines, traps, and nets in certain waters and replace the obsolete nomenclature "game wardens" with "conservation police officers."

4VAC15-340-40. Dip nets; generally.

A. Authorization to take fish with dip nets. A county dip net permit shall authorize the holder to take shad, herring, mullet, and suckers (daily creel (possession) limits for shad and herring are found in 4VAC15-320-25, there is no limit for mullet, and subsection D of this section provides limits for suckers), in the county named on the face of the permit with a dip net in inland waters, except where otherwise prohibited by local legislation or by the sections appearing in this chapter.

B. Persons required to have permit; inspection by ~~game wardens~~ conservation police officers. A dip net permit, or valid fishing license, shall be required for all persons using or

assisting in the use of a dip net and permits, or licenses, shall be carried at all times while using such nets and shall be subject to inspection by ~~game wardens~~ conservation police officers.

C. Release of certain fish netted. All fish, except shad, herring, mullet, suckers and carp, when taken with a dip net shall be returned to the water alive with as little injury as possible.

D. Special provisions applicable only to suckers. The following special provisions shall apply only to the taking of suckers, with a dip net:

1. Not more than 20 may be taken by any person in one day;

2. The open season for taking same with a dip net shall be from February 15 through May 15, both dates inclusive; and

3. Dip nets for taking such fish shall not be more than six feet square.

4VAC15-340-60. Seines, traps, and nets prohibited in certain areas.

A. It shall be unlawful to use seines and nets of any kind for the taking of fish from the public waters of the Roanoke (Staunton) and Dan Rivers in Campbell, Charlotte, Halifax, and Pittsylvania Counties, and in the City of Danville; provided, however, this section shall not be construed to prohibit the use of hand-landing nets for the landing of fish legally hooked or the taking of fish from these waters pursuant to the provisions of 4VAC15-360.

B. In Lick Creek and tributaries in Smyth and Bland Counties, in Bear Creek and Hungry Mother Creek above Hungry Mother Lake in Smyth County, and in Laurel Creek and tributaries upstream of Highway 16 bridge in Tazewell and Bland Counties, in Susong Branch and Mumpower Creek in Washington County and the City of Bristol, and in Timbertree Branch in Scott County, it shall be unlawful to use seines, nets, or traps; provided, however, this section shall not be construed to prohibit the use of hand-landing nets for the landing of fish legally hooked.

VA.R. Doc. No. R14-4054; Filed December 10, 2014, 9:02 a.m.

Final Regulation

Title of Regulation: **4VAC15-350. Fish: Gigs, Grab Hooks, Trotlines, Snares, Etc (amending 4VAC15-350-60).**

Statutory Authority: §§ 29.1-103, 29.1-501, and 29.1-502 of the Code of Virginia.

Effective Date: January 1, 2015.

Agency Contact: Phil Smith, Regulatory Coordinator, Department of Game and Inland Fisheries, 4010 West Broad Street, Richmond, VA 23230, telephone (804) 367-8341 or email phil.smith@dgif.virginia.gov.

Summary:

The amendments (i) require removal of fishing lines from trotlines, juglines, and set poles when not in use and (ii) clarify that snapping turtles are the only type of turtles that may be taken with these methods.

4VAC15-350-60. Trotlines, juglines, or set poles.

A. Generally. Except as otherwise provided by local legislation and by subsections B and C of this section, and except on waters stocked with trout and within 600 feet of any dam, it shall be lawful to use trotlines, juglines (single hook, including one treble hook, and line attached to a float), or set poles for the purpose of taking nongame fish (daily creel (possession) and length limits for nongame fish are found in 4VAC15-320-25) and snapping turtles (limits for snapping turtles are found in 4VAC15-360-10), provided that no live bait is used. Notwithstanding the provisions of this section, live bait other than game fish may be used on trotlines to take catfish in the Clinch River in the Counties of Russell, Scott, and Wise. Any person setting or in possession of a trotline, jugline, or set pole shall have it clearly marked by permanent means with his name, address, and telephone number, and is required to check all lines at least once each day, ~~and~~ remove all fish and animals caught, and remove all lines when not in use. This requirement shall not apply to landowners on private ponds, nor to a bona fide tenant or lessee on private ponds within the bounds of land rented or leased, nor to anyone transporting any such device from its place of purchase.

B. Quantico Marine Reservation. It shall be unlawful to fish with trotlines in any waters within the confines of Quantico Marine Reservation.

C. Additional jugline requirements. Jugline sets (except as exempt under subsection A of this section) shall be restricted to 20 per angler and must be attended (within sight) by anglers at all times. Also, in addition to being labeled with the angler's name, address, and telephone number, jugs shall also be labeled with a reflective marker that encircles the jugs to allow for visibility at night.

VA.R. Doc. No. R14-4055; Filed December 10, 2014, 9:08 a.m.

Final Regulation

Title of Regulation: **4VAC15-360. Fish: Aquatic Invertebrates, Amphibians, Reptiles, and Nongame Fish (amending 4VAC15-360-10).**

Statutory Authority: §§ 29.1-103, 29.1-501, and 29.1-502 of the Code of Virginia.

Effective Date: January 1, 2015.

Agency Contact: Phil Smith, Regulatory Coordinator, Department of Game and Inland Fisheries, 4010 West Broad Street, Richmond, VA 23230, telephone (804) 367-8341 or email phil.smith@dgif.virginia.gov.

Summary:

The amendments establish a recreational harvest season for snapping turtles that coincides with the commercial harvest season of June 1 through September 30.

4VAC15-360-10. Taking aquatic invertebrates, amphibians, reptiles, and nongame fish for private use.

A. Possession limits. Except as otherwise provided for in § 29.1-418 of the Code of Virginia, 4VAC15-20-130, subdivision 8 of 4VAC15-320-40 and the sections of this chapter, it shall be lawful to capture and possess live for private use and not for sale no more than five individuals of any single native or naturalized (as defined in 4VAC15-20-50) species of amphibian and reptile and 20 individuals of any single native or naturalized (as defined in 4VAC15-20-50) species of aquatic invertebrate and nongame fish unless specifically listed below:

1. The following species may be taken in unlimited numbers from inland waters statewide: carp, bowfin, longnose gar, mullet, yellow bullhead, brown bullhead, black bullhead, flat bullhead, snail bullhead, white sucker, northern hogsucker, gizzard shad, threadfin shad, blueback herring (see 4VAC15-320-25 for anadromous blueback herring limits), white perch, yellow perch, alewife (see 4VAC15-320-25 for anadromous alewife limits), stoneroller (hornyhead), fathead minnow, golden shiner, goldfish, and Asian clams.

2. See 4VAC15-320-25 for American shad, hickory shad, channel catfish, white catfish, flathead catfish, and blue catfish limits.

3. For the purpose of this chapter, "fish bait" shall be defined as native or naturalized species of minnows and chubs (Cyprinidae), salamanders (each under six inches in total length), crayfish, and hellgrammites. The possession limit for taking "fish bait" shall be 50 individuals in aggregate, unless said person has purchased "fish bait" and has a receipt specifying the number of individuals purchased by species, except salamanders and crayfish which cannot be sold pursuant to the provisions of 4VAC15-360-60 and 4VAC15-360-70. However, stonerollers (hornyheads), fathead minnows, golden shiners, and goldfish may be taken and possessed in unlimited numbers as provided for in subdivision 1 of this subsection.

4. The daily limit for bullfrogs shall be 15 and for snapping turtles shall be 5. Snapping turtles shall only be taken from June 1st to September 30th. Bullfrogs and snapping turtles may not be taken from the banks or waters of designated stocked trout waters.

5. The following species may not be taken in any number for private use: candy darter, eastern hellbender, diamondback terrapin, and spotted turtle.

6. Native amphibians and reptiles, as defined in 4VAC15-20-50, that are captured within the Commonwealth and possessed live for private use and not for sale may be liberated under the following conditions:

a. Period of captivity does not exceed 30 days;

b. Animals must be liberated at the site of capture;

c. Animals must have been housed separately from other wild-caught and domestic animals; and

d. Animals that demonstrate symptoms of disease or illness or that have sustained injury during their captivity may not be released.

B. Methods of taking species in subsection A. Except as otherwise provided for in the Code of Virginia, 4VAC15-20-130, 4VAC15-320-40, and other regulations of the board, and except in any waters where the use of nets is prohibited, the species listed in subsection A may only be taken by hand, hook and line, with a seine not exceeding four feet in depth by 10 feet in length, an umbrella type net not exceeding five by five feet square, small minnow traps with throat openings no larger than one inch in diameter, cast nets, and hand-held bow nets with diameter not to exceed 20 inches and handle length not to exceed eight feet (such cast net and hand-held bow nets when so used shall not be deemed dip nets under the provisions of § 29.1-416 of the Code of Virginia). Gizzard shad and white perch may also be taken from below the fall line in all tidal rivers of the Chesapeake Bay using a gill net in accordance with Virginia Marine Resources Commission recreational fishing regulations. Bullfrogs may also be taken by gigging or bow and arrow and, from private waters, by firearms no larger than .22 caliber rimfire. Snapping turtles may be taken for personal use with hoop nets not exceeding six feet in length with a throat opening not exceeding 36 inches.

C. Areas restricted from taking mollusks. Except as provided for in §§ 29.1-418 and 29.1-568 of the Code of Virginia, it shall be unlawful to take the spiny riversnail (Io fluvialis) in the Tennessee drainage in Virginia (Clinch, Powell and the North, South and Middle Forks of the Holston Rivers and tributaries). It shall be unlawful to take mussels from any inland waters of the Commonwealth.

D. Areas restricted from taking salamanders. Except as provided for in §§ 29.1-418 and 29.1-568 of the Code of Virginia, it shall be unlawful to take salamanders in Grayson Highlands State Park and on National Forest lands in the Jefferson National Forest in those portions of Grayson, Smyth and Washington Counties bounded on the east by State Route 16, on the north by State Route 603 and on the south and west by U.S. Route 58.

VA.R. Doc. No. R14-4063; Filed December 10, 2014, 9:15 a.m.

Final Regulation

REGISTRAR'S NOTICE: The Marine Resources Commission is claiming an exemption from Article 2 of the Administrative Process Act in accordance with § 2.2-4006 A 11 of the Code of Virginia; however, the commission is required to publish the full text of final regulations.

Title of Regulation: **4VAC20-620. Pertaining to Summer Flounder (amending 4VAC20-620-30, 4VAC20-620-40).**

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

Effective Date: December 10, 2014.

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

Summary:

This action establishes a 20-day consecutive landing period, beginning December 10, 2014, for any legally licensed summer flounder endorsement licensee's landing summer flounder harvested outside of Virginia waters.

4VAC20-620-30. Commercial harvest quota and allowable landings.

A. During each calendar year, allowable commercial landings of Summer Flounder shall be limited to a quota in total pounds calculated pursuant to the joint Mid-Atlantic Fishery Management Council/Atlantic States Marine Fisheries Commission Summer Flounder Fishery Management Plan, as approved by the National Marine Fisheries Service on August 6, 1992 (50 CFR Part 625); and shall be distributed as described in subsections B through G of this section.

B. The commercial harvest of Summer Flounder from Virginia tidal waters for each calendar year shall be limited to 300,000 pounds of the annual quota described in subsection A of this section. Of this amount, 142,114 pounds shall be set aside for Chesapeake Bay-wide harvest.

C. From the first Monday in January through ~~the day preceding the second Monday in~~ November 30 the allowable landings of Summer Flounder harvested outside of Virginia shall be limited to an amount of pounds equal to 70.7% of the quota described in subsection A of this section after deducting the amount specified in subsection B of this section.

D. From ~~the second Monday in November~~ December 1 through December 31, allowable landings of Summer Flounder harvested outside of Virginia shall be limited to an amount of pounds equal to 29.3% of the quota, as described in subsection A of this section, after deducting the amount specified in subsection B of this section, and as may be further modified by subsection E.

E. Should landings from the first Monday in January through ~~the day preceding the second Monday~~ in November 30 exceed or fall short of 70.7% of the quota described in subsection A of this section, any such excess shall be deducted from allowable landings described in subsection D of this section, and any such shortage shall be added to the allowable landings as described in subsection D of this section. Should the commercial harvest specified in subsection B of this section be projected as less than 300,000 pounds, any such shortage shall be added to the allowable landings described in subsection D of this section.

F. The Marine Resources Commission will give timely notice to the industry of the calculated poundages and any adjustments to any allowable landings described in subsections C and D of this section. It shall be unlawful for any person to harvest or to land Summer Flounder for commercial purposes after the commercial harvest or any allowable landings as described in this section have been attained and announced as such. If any person lands Summer Flounder after the commercial harvest or any allowable landing have been attained and announced as such, the entire amount of Summer Flounder in that person's possession shall be confiscated.

G. It shall be unlawful for any buyer of seafood to receive any Summer Flounder after any commercial harvest or landing quota as described in this section has been attained and announced as such.

4VAC20-620-40. Commercial vessel possession and landing limitations.

A. It shall be unlawful for any person harvesting Summer Flounder outside of Virginia's waters to do any of the following, except as described in subsections B, C, and D of this section:

1. Possess aboard any vessel in Virginia waters any amount of Summer Flounder in excess of 10% by weight of Atlantic croaker or the combined landings, on board a vessel, of black sea bass, scup, squid, scallops and Atlantic mackerel.

2. Possess aboard any vessel in Virginia waters any amount of Summer Flounder in excess of 1,500 pounds landed in combination with Atlantic croaker.

3. Fail to sell the vessel's entire harvest of all species at the point of landing.

B. From the second Wednesday in March through ~~the day preceding the second Monday in~~ November 30, or until it has been projected and announced that 85% of the allowable landings have been taken, it shall be unlawful for any person harvesting Summer Flounder outside of Virginia waters to do any of the following:

1. Possess aboard any vessel in Virginia waters any amount of Summer Flounder in excess of the combined total of the Virginia landing limit described in subdivision 3 of this subsection and the amount of the legal North Carolina landing limit or trip limit.

2. Land Summer Flounder in Virginia for commercial purposes more than twice during each consecutive 20-day period, with the first 20-day period beginning on the second Wednesday in March.

3. Land in Virginia more than 12,500 pounds of Summer Flounder during each consecutive 20-day period, with the first 20-day period beginning on the second Wednesday in March.

4. Land in Virginia any amount of Summer Flounder more than once in any consecutive five-day period.

C. From ~~the second Monday in November~~ December 1 through December 31 of each year, or until it has been projected and announced that 85% of the allowable landings have been taken, it shall be unlawful for any person harvesting Summer Flounder outside of Virginia waters to do any of the following:

1. Possess aboard any vessel in Virginia waters any amount of Summer Flounder in excess of the combined total of the Virginia landing limit described in subdivision 3 of this subsection and the amount of the legal North Carolina landing limit or trip limit.

2. Land Summer Flounder in Virginia for commercial purposes more than twice during each consecutive ~~15-day~~ 20-day period, with the first ~~15-day~~ 20-day period beginning on ~~the second Monday in November~~ December 1.

3. Land in Virginia more than a total of 10,000 pounds of Summer Flounder during each consecutive ~~15-day~~ 20-day period, with the first ~~15-day~~ 20-day period beginning on ~~the second Monday in November~~ December 1.

4. Land in Virginia any amount of Summer Flounder more than once in any consecutive five-day period.

D. From January 1 through December 31 of each year, any boat or vessel issued a valid federal Summer Flounder moratorium permit and owned and operated by a legal Virginia Commercial Hook-and-Line Licensee that possesses a Restricted Summer Flounder Endorsement shall be restricted to a possession and landing limit of 200 pounds of Summer Flounder, except as described in 4VAC20-620-30 F.

E. Upon request by a marine police officer, the seafood buyer or processor shall offload and accurately determine the total weight of all Summer Flounder aboard any vessel landing Summer Flounder in Virginia.

F. Any possession limit described in this section shall be determined by the weight in pounds of Summer Flounder as customarily packed, boxed and weighed by the seafood buyer or processor. The weight of any Summer Flounder in pounds found in excess of any possession limit described in this section shall be prima facie evidence of violation of this chapter. Persons in possession of Summer Flounder aboard any vessel in excess of the possession limit shall be in violation of this chapter unless that vessel has requested and been granted safe harbor. Any buyer or processor offloading or accepting any quantity of Summer Flounder from any vessel in excess of the possession limit shall be in violation of this chapter, except as described by subsection I of this section. A buyer or processor may accept or buy Summer Flounder from a vessel that has secured safe harbor, provided that vessel has satisfied the requirements described in subsection I of this section.

G. If a person violates the possession limits described in this section, the entire amount of Summer Flounder in that person's possession shall be confiscated. Any confiscated Summer Flounder shall be considered as a removal from the appropriate commercial harvest or landings quota. Upon confiscation, the marine police officer shall inventory the confiscated Summer Flounder and, at a minimum, secure two bids for purchase of the confiscated Summer Flounder from approved and licensed seafood buyers. The confiscated fish will be sold to the highest bidder and all funds derived from such sale shall be deposited for the Commonwealth pending court resolution of the charge of violating the possession limits established by this chapter. All of the collected funds will be returned to the accused upon a finding of innocence or forfeited to the Commonwealth upon a finding of guilty.

H. It shall be unlawful for a licensed seafood buyer or federally permitted seafood buyer to fail to contact the Marine Resources Commission Operation Station prior to a vessel offloading Summer Flounder harvested outside of Virginia. The buyer shall provide to the Marine Resources Commission the name of the vessel, its captain, an estimate of the amount in pounds of Summer Flounder on board that vessel, and the anticipated or approximate offloading time. Once offloading of any vessel is complete and the weight of the landed Summer Flounder has been determined, the buyer shall contact the Marine Resources Commission Operations Station and report the vessel name and corresponding weight of Summer Flounder landed. It shall be unlawful for any person to offload from a boat or vessel for commercial purposes any Summer Flounder during the period of 9 p.m. to 7 a.m.

I. Any boat or vessel that has entered Virginia waters for safe harbor shall only offload Summer Flounder when the state that licenses that vessel requests to transfer quota to Virginia, in the amount that corresponds to that vessel's possession limit, and the commissioner agrees to accept that transfer of quota.

J. After any commercial harvest or landing quota as described in 4VAC20-620-30 has been attained and announced as such, any boat or vessel possessing Summer Flounder on board may enter Virginia waters for safe harbor but shall contact the Marine Resources Commission Operation Center in advance of such entry into Virginia waters.

K. It shall be unlawful for any person harvesting Summer Flounder outside of Virginia waters to possess aboard any vessel, in Virginia, any amount of Summer Flounder, once it has been projected and announced that 100% of the quota described in 4VAC20-620-30 A has been taken.

VA.R. Doc. No. R15-4230; Filed December 10, 2014, 1:30 p.m.

TITLE 6. CRIMINAL JUSTICE AND CORRECTIONS

BOARD OF JUVENILE JUSTICE

Fast-Track Regulation

Title of Regulation: **6VAC35-51. Standards for Interim Regulation of Children's Residential Facilities (repealing 6VAC35-51-10 through 6VAC35-51-1090).**

Statutory Authority: §§ 16.1-309.9, 66-10, and 66-24 of the Code of Virginia.

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: January 28, 2015.

Effective Date: February 13, 2015.

Agency Contact: Barbara Peterson-Wilson, Regulatory and Policy Coordinator, Department of Juvenile Justice, 600 East Main Street, 20th Floor, P.O. Box 1110, Richmond, VA 23219, telephone (804) 588-3902, FAX (804) 371-6490, or email barbara.peterson-wilson@djj.virginia.gov.

Basis: Section 66-4 of the Code of Virginia creates the Board of Juvenile Justice while § 66-10 of the Code of Virginia states that the board shall have the power and duty to promulgate such regulations as may be necessary to carry out the provisions of Title 66 of the Code of Virginia and the other laws of the Commonwealth. Section 66-24 of the Code of Virginia requires the board to promulgate regulations for licensure or certification of community group homes or other residential facilities that contract with or are rented for the care of juveniles in direct state care. The board's regulations shall address the services required to be provided in such facilities as it may deem appropriate to ensure the welfare and safety of the juveniles. In addition, the board's regulations shall include, but need not be limited to (i) specifications for the structure and accommodations of such facilities according to the needs of the juveniles to be placed in the home or facility; (ii) rules concerning allowable activities, local government- and group home- or residential care facility-imposed curfews, and study, recreational, and bedtime hours; and (iii) a requirement that each home or facility have a community liaison who shall be responsible for facilitating cooperative relationships with the neighbors, the school system, local law enforcement, local government officials, and the community at large.

Purpose: The Regulation Governing Juvenile Group Homes and Halfway Houses (6VAC35-41), the Regulation Governing Juvenile Correctional Centers (6VAC35-71), and the Regulation Governing Juvenile Secure Detention Centers (6VAC35-101) have been approved and finalized through the regulatory process and became effective on January 1, 2014. Each of the new residential regulations contains a section titled "Previous regulations terminated" (6VAC35-41-30, 6VAC35-71-20, and 6VAC35-101-30) stating that 6VAC35-51 is replaced by the applicable new residential regulation. As such, 6VAC35-51 does not have any legal or operational effect. Each of these regulations contains language that is specific to the type of facility. The Standards for the Interim Regulation of Children's Residential Facilities contained language that addressed juvenile residential facilities generally and is no longer necessary.

Rationale for Using Fast-Track Process: The Regulation Governing Juvenile Group Homes and Halfway Houses (6VAC35-41), the Regulation Governing Juvenile Correctional Centers (6VAC35-71), and the Regulation Governing Juvenile Secure Detention Centers (6VAC35-101) became effective on January 1, 2014. Each of these regulations contains the following provision:

> "This chapter replaces the Standards for the Interim Regulation of Children's Residential Facilities, (6VAC35-51), and the Standards for Juvenile Residential Facilities, (6VAC35-140), for the regulation of all [named type of facility] as defined herein. The Standards for the Interim Regulation of Children's Residential Facilities and the Standards for Juvenile Residential Facilities remain in effect for [named other types of facilities not regulated by the specific chapter], regulated by the board, until such time as the board adopts new regulations related thereto."

The Standards for the Interim Regulation of Children's Residential Facilities remained in effect for the juvenile group homes, juvenile secure detention centers, and juvenile correctional centers regulated by the board until January 1, 2014, when the new regulations become effective. Upon the regulations' effective date, the three new regulations replaced the Standards for the Interim Regulation of Children's Residential Facilities (6VAC35-51). As such, 6VAC35-51 does not have any legal or operational effect.

It is anticipated that the repeal of 6VAC35-51 will be noncontroversial as it has been superseded by new residential regulations.

Substance: This regulatory action does not propose any new substantive provisions or substantive changes. The Standards for the Interim Regulation of Children's Residential Facilities, 6VAC35-51, will be repealed as new residential regulations have become effective and supersede 6VAC35-51.

Issues: Prior to January 1, 2014, when the Regulation Governing Juvenile Group Homes and Halfway Houses (6VAC35-41), the Regulation Governing Juvenile Correctional Centers (6VAC35-71), and the Regulation Governing Juvenile Secure Detention Centers (6VAC35-101) became effective, facilities regulated by the board were governed by both the Standards for the Interim Regulation of Children's Residential Facilities (6VAC35-51) and the Standards for Juvenile Residential Facilities (6VAC35-140), unless specifically exempted.

6VAC35-51 and 6VAC35-140 were superseded by provisions in 6VAC35-41, 6VAC35-71, and 6VAC35-101. The facilities

formerly regulated by the provisions in 6VAC35-51 and 6VAC35-140 are now governed by 6VAC35-41, 6VAC35-71, and 6VAC35-101, as applicable. Retaining 6VAC35-51 and 6VAC35-140 as active regulatory chapters could cause confusion for the regulated entities.

Repealing the Standards for the Interim Regulation of Children's Residential Facilities benefits the locally and regionally operated juvenile secure detention centers and locally operated juvenile group homes and halfway houses and state operated juvenile correctional centers. The new residential regulations govern specific types of juvenile facilities providing greater clarity of the regulatory requirements. In repealing the superseded regulatory chapter, confusion as to which active regulatory chapters are applicable to the facilities will be avoided.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The Board of Juvenile Justice (Board) proposes to repeal its regulation that, until recently, governed how children's residential facilities were run (standards contained in 6VAC35-51).

Result of Analysis. Benefits likely outweigh costs for this proposed regulatory change.

Estimated Economic Impact. The Board of Juvenile Justice (Board) proposes to repeal its regulation that, until recently, governed how children's residential facilities were run (standards contained in 6VAC35-51). The Board has replaced these standards with a Regulation Governing Juvenile Group Homes and Halfway Houses (6VAC35-41), a Regulation Governing Juvenile Correctional Centers (6VAC35-71) and a Regulation Governing Juvenile Secure Detention Centers (6VAC35-101), all of which became effective January 1, 2014.

Because the standards in 6VAC35-51 are now obsolete, no affected entity is likely to incur costs on account of this repeal. Affected entities are likely to benefit from this action as it will remove a potential source of confusion from the Virginia Administrative Code.

Businesses and Entities Affected. Board staff reports that, until recently, these standards affected four state operated juvenile correctional centers, 24 locally operated juvenile secure detention centers and 19 group homes.

Localities Particularly Affected. No locality will be particularly affected by this proposed regulatory action.

Projected Impact on Employment. This regulatory action is unlikely to have any impact on employment in the Commonwealth.

Effects on the Use and Value of Private Property. This regulatory action is unlikely to have any effect on the use or value of private property.

Small Businesses: Costs and Other Effects. No small businesses will incur costs on account of this regulatory action.

Small Businesses: Alternative Method that Minimizes Adverse Impact. No small businesses will incur costs on account of this regulatory action.

Real Estate Development Costs. This regulatory action will likely have no effect on real estate development costs in the Commonwealth.

Legal Mandate.

General: The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007.04 of the Code of Virginia and Executive Order Number 14 (2010). Section 2.2-4007.04 requires that such economic impact analyses determine the public benefits and costs of the proposed amendments. Further the report should include but not be limited to:

- the projected number of businesses or other entities to whom the proposed regulation would apply,
- the identity of any localities and types of businesses or other entities particularly affected,
- the projected number of persons and employment positions to be affected,
- the projected costs to affected businesses or entities to implement or comply with the regulation, and
- the impact on the use and value of private property.

Small Businesses: If the proposed regulation will have an adverse effect on small businesses, § 2.2-4007.04 requires that such economic impact analyses include:

- an identification and estimate of the number of small businesses subject to the proposed regulation,
- the projected reporting, recordkeeping, and other administrative costs required for small businesses to comply with the proposed regulation, including the type of professional skills necessary for preparing required reports and other documents,
- a statement of the probable effect of the proposed regulation on affected small businesses, and
- a description of any less intrusive or less costly alternative methods of achieving the purpose of the proposed regulation.

Additionally, pursuant to § 2.2-4007.1, if there is a finding that a proposed regulation may have an adverse impact on small business, the Joint Commission on Administrative Rules (JCAR) is notified at the time the proposed regulation is submitted to the Virginia Register of Regulations for publication. This analysis shall represent DPB's best estimate for the purposes of public review and comment on the proposed regulation.

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

Summary:

The Board of Juvenile Justice is repealing 6VAC35-51 because the regulation is obsolete. Effective January 1, 2014, 6VAC35-51 was replaced by Regulation Governing Juvenile Group Homes and Halfway Houses (6VAC35-41), Regulation Governing Juvenile Correctional Centers (6VAC35-71), and Regulation Governing Juvenile Secure Detention Centers (6VAC35-101).

VA.R. Doc. No. R15-3976; Filed December 3, 2014, 1:23 p.m.

Fast-Track Regulation

Title of Regulation: **6VAC35-140. Standards for Juvenile Residential Facilities (repealing 6VAC35-140-10 through 6VAC35-140-800).**

Statutory Authority: §§ 16.1-309.9, 66-10, and 66-25.1 of the Code of Virginia.

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: January 28, 2015.

Effective Date: February 13, 2015.

Agency Contact: Barbara Peterson-Wilson, Regulatory and Policy Coordinator, Department of Juvenile Justice, 600 East Main Street, 20th Floor, P.O. Box 1110, Richmond, VA 23218, telephone (804) 588-3902, FAX (804) 371-6490, or email barbara.peterson-wilson@djj.virginia.gov.

Basis: Section 66-4 of the Code of Virginia creates the Board of Juvenile Justice while § 66-10 of the Code of Virginia states that the board shall have the power and duty to promulgate such regulations as may be necessary to carry out the provisions of Title 66 of the Code of Virginia and the other laws of the Commonwealth. Section 66-24 of the Code of Virginia requires the board to promulgate regulations for licensure or certification of community group homes or other residential facilities that contract with or are rented for the care of juveniles in direct state care. The board's regulations must address the services required to be provided in such facilities as it may deem appropriate to ensure the welfare and safety of the juveniles. In addition, the board's regulations must include, but need not be limited to (i) specifications for the structure and accommodations of such facilities according to the needs of the juveniles to be placed in the home or facility; (ii) rules concerning allowable activities, local government- and group home- or residential care facility-imposed curfews, and study, recreational, and bedtime hours; and (iii) a requirement that each home or facility have a community liaison who shall be responsible for facilitating cooperative relationships with the neighbors, the school system, local law enforcement, local government officials, and the community at large.

Purpose: The Regulation Governing Juvenile Group Homes and Halfway Houses (6VAC35-41), the Regulation Governing Juvenile Correctional Centers (6VAC35-71), and the Regulation Governing Juvenile Secure Detention Centers (6VAC35-101) have been approved and finalized through the regulatory process and became effective on January 1, 2014.

Each of the new residential regulations contains a section titled "Previous regulations terminated" (6VAC35-41-30, 6VAC35-71-20, and 6VAC35-101-30) stating that 6VAC35-140 is replaced by the applicable new residential regulation. As such, 6VAC35-140 does not have any legal or operational effect. Each of these regulations contains language that is specific to the type of facility. The Standards for Juvenile Residential Facilities contained language that addressed juvenile residential facilities in the juvenile justice system generally and is no longer necessary.

Rationale for Using Fast-Track Process: The Regulation Governing Juvenile Group Homes and Halfway Houses (6VAC35-41), the Regulation Governing Juvenile Correctional Centers (6VAC35-71), and the Regulation Governing Juvenile Secure Detention Centers (6VAC35-101) became effective on January 1, 2014. Each of these regulations contains the following provision:

> "This chapter replaces the Standards for the Interim Regulation of Children's Residential Facilities, (6VAC35-51), and the Standards for Juvenile Residential Facilities, (6VAC35-140), for the regulation of all [named type of facility] as defined herein. The Standards for the Interim Regulation of Children's Residential Facilities and the Standards for Juvenile Residential Facilities remain in effect for [named other types of facilities not regulated by the specific chapter], regulated by the board, until such time as the board adopts new regulations related thereto."

The Standards for Juvenile Residential Facilities remained in effect for the juvenile group homes, juvenile secure detention centers, and juvenile correctional centers regulated by the Board until January 1, 2014, when the new regulations become effective. Upon the regulations' effective date, the three new regulations replaced the Standards for Juvenile Residential Facilities (6VAC35-140).

It is anticipated that the repeal of 6VAC35-140 will be noncontroversial as it has been superseded by new residential regulations.

Substance: This regulatory action does not propose any new substantive provisions or substantive changes. The Standards for Juvenile Residential Facilities (6VAC35-140) will be repealed as new residential regulations have become effective and supersede the provision in 6VAC35-140.

Issues: Prior to January 1, 2014, when the Regulation Governing Juvenile Group Homes and Halfway Houses (6VAC35-41), the Regulation Governing Juvenile Correctional Centers (6VAC35-71), and the Regulation Governing Juvenile Secure Detention Centers (6VAC35-101)

became effective, facilities regulated by the board were governed by both the Standards for the Interim Regulation of Children's Residential Facilities (6VAC35-51) and the Standards for Juvenile Residential Facilities (6VAC35-140), unless specifically exempted.

6VAC35-51 and 6VAC35-140 were superseded by provisions in 6VAC35-41, 6VAC35-71, and 6VAC35-101. The facilities formerly regulated by the provisions in 6VAC35-51 and 6VAC35-140 are now governed by 6VAC35-41, 6VAC35-71, and 6VAC35-101, as applicable. Retaining 6VAC35-51 and 6VAC35-140 as active regulatory chapters could cause confusion for the regulated entities.

Repealing the Standards for the Interim Regulation of Children's Residential Facilities benefits the locally and regionally operated juvenile secure detention centers and locally operated juvenile group homes and halfway houses and state operated juvenile correctional centers. The new residential regulations govern specific types of juvenile facilities providing greater clarity of the regulatory requirements. In repealing the superseded regulatory chapter, confusion as to which active regulatory chapters are applicable to the facilities will be avoided.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The Board of Juvenile Justice (Board) proposes to repeal its regulation that, until recently, governed Standards for Juvenile Residential Facilities (6VAC35-140).

Result of Analysis. Benefits likely outweigh costs for this proposed regulatory change.

Estimated Economic Impact. The Board of Juvenile Justice (Board) proposes to repeal its regulation that, until recently, governed Standards for Juvenile Residential Facilities (6VAC35-140). The Board has replaced these standards with a Regulation Governing Juvenile Group Homes and Halfway Houses (6VAC35-41), a Regulation Governing Juvenile Correctional Centers (6VAC35-71) and a Regulation Governing Juvenile Secure Detention Centers (6VAC35-101), all of which became effective January 1, 2014.

Because the standards in 6VAC35-140 are now obsolete, no affected entity is likely to incur costs on account of this repeal. Affected entities are likely to benefit from this action as it will remove a potential source of confusion from the Virginia Administrative Code.

Businesses and Entities Affected. Board staff reports that, until recently, these standards affected four state operated juvenile correctional centers, 24 locally operated juvenile secure detention centers and 19 group homes.

Localities Particularly Affected. No locality will be particularly affected by this proposed regulatory action.

Projected Impact on Employment. This regulatory action is unlikely to have any impact on employment in the Commonwealth.

Effects on the Use and Value of Private Property. This regulatory action is unlikely to have any effect on the use or value of private property.

Small Businesses: Costs and Other Effects. No small businesses will incur costs on account of this regulatory action.

Small Businesses: Alternative Method that Minimizes Adverse Impact. No small businesses will incur costs on account of this regulatory action.

Real Estate Development Costs. This regulatory action will likely have no effect on real estate development costs in the Commonwealth.

Legal Mandate.

General: The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007.04 of the Code of Virginia and Executive Order Number 14 (2010). Section 2.2-4007.04 requires that such economic impact analyses determine the public benefits and costs of the proposed amendments. Further the report should include but not be limited to:

- the projected number of businesses or other entities to whom the proposed regulation would apply,
- the identity of any localities and types of businesses or other entities particularly affected,
- the projected number of persons and employment positions to be affected,
- the projected costs to affected businesses or entities to implement or comply with the regulation, and
- the impact on the use and value of private property.

Small Businesses: If the proposed regulation will have an adverse effect on small businesses, § 2.2-4007.04 requires that such economic impact analyses include:

- an identification and estimate of the number of small businesses subject to the proposed regulation,
- the projected reporting, recordkeeping, and other administrative costs required for small businesses to comply with the proposed regulation, including the type of professional skills necessary for preparing required reports and other documents,
- a statement of the probable effect of the proposed regulation on affected small businesses, and
- a description of any less intrusive or less costly alternative methods of achieving the purpose of the proposed regulation.

Additionally, pursuant to § 2.2-4007.1, if there is a finding that a proposed regulation may have an adverse impact on small business, the Joint Commission on Administrative Rules (JCAR) is notified at the time the proposed regulation is submitted to the Virginia Register of Regulations for publication. This analysis shall represent DPB's best estimate

for the purposes of public review and comment on the proposed regulation.

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

Summary:

The Board of Juvenile Justice is repealing 6VAC35-140 because the regulation is obsolete. Effective January 1, 2014, 6VAC35-140 was replaced by Regulation Governing Juvenile Group Homes and Halfway Houses (6VAC35-41), Regulation Governing Juvenile Correctional Centers (6VAC35-71), and Regulation Governing Juvenile Secure Detention Centers (6VAC35-101).

VA.R. Doc. No. R15-3975; Filed December 3, 2014, 1:25 p.m.

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TITLE 9. ENVIRONMENT

STATE WATER CONTROL BOARD

Proposed Regulation

Title of Regulation: **9VAC25-900. Certification of Nonpoint Source Nutrient Credits (adding 9VAC25-900-10 through 9VAC25-900-350).**

Statutory Authority: § 62.1-44.19:20 of the Code of Virginia.

Public Hearing Information:

February 11, 2015 - 2 p.m. - Department of Environmental Quality, PRO Training Room, 4949-A Cox Road, Glen Allen, VA 23060

February 12, 2015 - 2 p.m. - Department of Environmental Quality, Blue Ridge Regional Office, 3019 Peters Creek Road, Roanoke, VA 24019

Public Comment Deadline: March 16, 2015.

Agency Contact: Debra Harris, Department of Environmental Quality, 629 East Main Street, P.O. Box 1105, Richmond, VA 23218, telephone (804) 698-4209, FAX (804) 698-4346, or email debra.harris@deq.virginia.gov.

Basis: The state authority to promulgate the proposed regulation is pursuant to the Chesapeake Bay Watershed Nutrient Credit Exchange Program, Article 4.02 (§ 62.1-44.19:12 et seq.) of Chapter 3.1 of Title 62.1 of the Code of Virginia. Specifically, the authority for the State Water Control Board to develop regulations is at § 62.1-44.19:20 of the Code of Virginia, which states under subsection A: "The Board shall adopt regulations for the purpose of establishing procedures for the certification of nonpoint source nutrient credits." Under § 62.1-44.19:20 B, the regulatory language may include but not be limited to (i) establishing procedures for the certification and registration of credits; (ii) establishing credit calculation procedures; (iii) providing certification of credits on a temporal basis; (iv) establishing requirements to reasonably assure the generation of credits; (v) establishing reporting requirements; (vi) providing the department the ability to audit/inspect for compliance; (vii) providing that the option to acquire nutrient credits for compliance purposes shall not eliminate any requirement to comply with local water quality requirements; (viii) establishing a credit retirement requirement; and (ix) establishing other requirements as the board deems necessary and appropriate.

Additionally, subdivision 10 of § 62.1-44.15 of the Code of Virginia of the State Water Control Law authorizes the State Water Control Board to adopt such regulations as it deems necessary to enforce the general water quality management program of the board in all or part of the Commonwealth.

Purpose: Pursuant to § 62.1-44.19:20 of the Code of Virginia, the board is required to adopt regulations for the certification of nonpoint source nutrient credits. Nonpoint credits established by the board in accordance with the legislation and this regulatory action may include credits generated from agricultural and urban stormwater best management practices, management of animal feeding operations, land use conversion, stream or wetlands restoration, shellfish aquaculture, and other established or innovative methods of nutrient control or removal.

Certified nonpoint source nutrient credits will be placed on a registry of credits that will be developed. The certified credits that are placed on this registry will be part of an enforceable market-based trading program that will involve the exchange of pollution allocations between sources. Currently, most programs involve exchanges between different point sources; however, this regulation is anticipated to make available additional nonpoint source nutrient credits to further trading avenues such as point source to nonpoint source trades or nonpoint to nonpoint trades. These trades will be part of the overall goal of meeting the reductions assigned by the Chesapeake Bay Watershed Implementation Plan and the Chesapeake Bay total maximum daily load (TMDL).

This regulation is another step towards a successful trading program. The regulation provides clarity and assurances regarding the process for certification and generation of nonpoint source nutrient credits for both the nutrient credit generating entity and those that purchase the nutrient credits.

Substance: The substantive provisions of this regulatory action are consistent with the specifics outlined in § 62.1-44.19:20 of the Code of Virginia and include the following:

• Application procedures for certifying credits that may be generated from effective nutrient controls or removal practices including agricultural and urban stormwater best management practices, land use conversion, stream or wetlands projects, and other appropriate methods of nutrient control or removal. The application procedures include the submittal of necessary information for determining whether and how many nutrient credits are generated by the nutrient credit-generating entity.

• The approval process for certification of those credits including provisions for retirement, registration, and release for exchange.

• The practices, actions, or levels of reductions that must be in place before credits can be generated are specified for establishing the baseline for the specific type of the nutrient credit-generating entity and are provided and detailed in the proposed regulation.

• Compliance and enforcement criteria for a nutrient credit-generating entity.

• Appropriate fees and the process for calculation and submittal of such fees.

• Requirements to reasonably assure the generation of the credit depending on the nature of the credit-generating activity and use, such as legal instruments for perpetual credits, operation and maintenance requirements, and associated financial assurance requirements are detailed in this regulation.

Issues: The primary advantage of this regulatory action is that the proposed regulation will provide clarity and certainty for the nutrient trading market by establishing appropriate procedures for the certification and generation of nonpoint source credits. This is an advantage to the regulated community, the public, and the Commonwealth as certainty in this market will help meet commitments outlined in the Chesapeake Bay Watershed Implementation Plan and other TMDLs. The framework and content of this regulatory action largely tracks the specifics outlined in § 62.1-44.19:20 of State Water Control Law regarding the promulgation of these regulations. In working with the regulatory advisory panel to develop the proposed regulations, the Department of Environmental Quality was careful to minimize disadvantages and to develop a program that provides clarity and certainty for those seeking to certify the generation of nonpoint source nutrient credits. This proposed regulatory action should pose no disadvantages to the public or to the Commonwealth.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The State Water Control Board (Board) proposes to establish in regulation the process for the certification of nonpoint source nitrogen and phosphorus nutrient credits. The regulation includes application procedures, baseline requirements, credit calculation procedures, release and registration of credits, compliance and reporting requirements for nutrient credit-generating entities, enforcement requirements, application fees, and financial assurance requirements. Nonpoint source nutrient credits must be certified by the Department of Environmental Quality prior to release, placement on the registry and exchange. The agency developed this regulation as required pursuant to Chapter 748 of the 2012 Acts of Assembly.

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

Estimated Economic Impact. Nutrient trading creates revenue opportunities and reduces costs associated with protecting the environment. The opportunity for nutrient trading arises because large differences in the cost to reduce a pound of nitrogen or phosphorus exist among various sectors and practices. In a trading market, sources that can reduce nutrients at low cost have an economic incentive to make reductions below target levels and then sell the credits to those facing higher costs. Trading therefore creates new revenue opportunities for farmers, entrepreneurs, and others who can generate nutrient credits. At the same time, trading allows land developers and other entities that face higher nutrient reduction costs to save money by purchasing credits to meet a portion of their nutrient reduction obligations. As a result, trading helps achieve overall nutrient reductions in the Chesapeake Bay watershed and elsewhere in the Commonwealth in a more cost-effective manner.

The framework and content of this regulatory action largely tracks the specifics outlined in Chapter 748 of the 2012 Acts of Assembly. Additionally, this program has already been in operation through guidance documents. Placing the program specifics in regulation is beneficial in that it helps improve clarity and helps ensure consistent procedures for the approval of nonpoint source nutrient banks. The nutrient trading program itself is beneficial in that it improves efficiency and reduces the cost of economic development while maintaining environmental standards.

Nonpoint credits established by the Board in accordance with the legislation and this regulatory action may include credits generated from agricultural and urban stormwater best management practices, management of animal feeding operations, land use conversion, stream or wetlands restoration, shellfish aquaculture, and other established or innovative methods of nutrient control or removal. These nutrient credits can be sold to businesses or other entities that wish to develop land, new or expanding point source discharges required to offset any increase in nutrient load or permitted Municipal Separate Stormwater Sewer Systems required to reduce nutrients under the Chesapeake Bay Total Maximum Daily Load (TMDL).

Certified nonpoint source nutrient credits are to be placed on a registry of credits. The certified credits that are placed on this registry are to be part of an enforceable market-based trading program that involves the exchange of pollution allocations between sources. Currently, most trades involve exchanges between different point sources; however, the program under this regulation makes available nonpoint source nutrient credits to further trading avenues such as point source to nonpoint source trades or nonpoint to nonpoint trades. These trades contribute to the overall goal of meeting the reductions assigned by the Chesapeake Bay Watershed Implementation Plan and the Chesapeake Bay TMDL.

Businesses and Entities Affected. The nutrient trading program and the proposed regulation potentially affect owners of land that may earn nutrient credits from agricultural and urban stormwater best management practices, management of animal feeding operations, land use conversion, stream or wetlands restoration, shellfish aquaculture, and other established or innovative methods of nutrient control or removal. Land developers are also affected in that they will be likely buyers of these credits.

Localities Particularly Affected. The nonpoint source nutrient certification program under the proposed regulation applies to localities throughout the Commonwealth. These credits can be certified and used statewide to offset new development. There is likely to be particular demand for the use of the credits within the Chesapeake Bay watershed.

Projected Impact on Employment. By reducing the cost of economic development while maintaining environmental standards, the nutrient trading program and the proposed regulation may positively affect employment.

Effects on the Use and Value of Private Property. The nutrient trading program and the proposed regulation may increase the value of land that can be used for nonpoint source nutrient banks.

Small Businesses: Costs and Other Effects. The nutrient trading program and the proposed regulation may reduce development costs for small businesses.

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

Real Estate Development Costs. The nutrient trading program and the proposed regulation may reduce real estate development costs.

Legal Mandate. General: The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007.04 of the Code of Virginia and Executive Order Number 14 (2010). Section 2.2-4007.04 requires that such economic impact analyses determine the public benefits and costs of the proposed amendments. Further the report should include but not be limited to:

- the projected number of businesses or other entities to whom the proposed regulatory action would apply,
- the identity of any localities and types of businesses or other entities particularly affected,
- the projected number of persons and employment positions to be affected,
- the projected costs to affected businesses or entities to implement or comply with the regulation, and
- the impact on the use and value of private property.

Small Businesses: If the proposed regulatory action will have an adverse effect on small businesses, § 2.2-4007.04 requires that such economic impact analyses include:

- an identification and estimate of the number of small businesses subject to the proposed regulation,
- the projected reporting, recordkeeping, and other administrative costs required for small businesses to comply with the proposed regulation, including the type of professional skills necessary for preparing required reports and other documents,
- a statement of the probable effect of the proposed regulation on affected small businesses, and
- a description of any less intrusive or less costly alternative methods of achieving the purpose of the proposed regulation.

Additionally, pursuant to § 2.2-4007.1, if there is a finding that a proposed regulation may have an adverse impact on small business, the Joint Commission on Administrative Rules (JCAR) is notified at the time the proposed regulation is submitted to the Virginia Register of Regulations for publication. This analysis shall represent DPB's best estimate for the purposes of public review and comment on the proposed regulation.

Agency's Response to Economic Impact Analysis: The department has no comment.

Summary:

Pursuant to Chapter 748 of the 2012 Acts of Assembly, the proposed regulation establishes the process for the certification of nonpoint source nitrogen and phosphorus nutrient credits. The proposed regulation includes application procedures, baseline requirements, credit calculation procedures, release and registration of credits, compliance and reporting requirements for nutrient credit-generating entities, enforcement requirements, application fees, and financial assurance requirements. Nonpoint source nutrient credits must be certified by the Department of Environmental Quality prior to release, placement on the registry, and exchange.

CHAPTER 900
CERTIFICATION OF NONPOINT SOURCE NUTRIENT CREDITS

Part I
Definitions

9VAC25-900-10. Definitions.

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

"300 animal units" means the term as defined in 9VAC25-192-10.

"Act" means the Chesapeake Bay Watershed Nutrient Credit Exchange Program, Article 4.02 (§ 62.1-44.19:12 et seq.) of Chapter 3.1 of Title 62.1 of the Code of Virginia.

"Agricultural lands" means cropland, hayland, or pastures.

"Animal feeding operation" means the term as defined by 9VAC25-31-10.

"Applicant" means the person who submits an application to the department for nutrient credit certification pursuant to this chapter.

"Baseline" means the practices, actions, or levels of reductions that must be in place before credits can be generated. The best management practices to be implemented for achieving baseline are provided in 9VAC25-900-100.

"Best management practice," "practice," or "BMP" means a structural practice, nonstructural practice, or other management practice used to prevent or reduce nutrient loads reaching surface waters or the adverse effects thereof.

"Board" means the State Water Control Board.

"CDA" means contributing drainage area.

"Certification of nutrient credits" or "nutrient credit certification" means the approval of nutrient credits issued by the department as specified in 9VAC25-900-80 F.

"Chesapeake Bay Watershed" means the land areas draining to the following Virginia river basins: the Potomac River Basin, the James River Basin, the Rappahannock River Basin, the Chesapeake Bay and small coastal basins, or the York River Basin.

"Concentrated animal feeding operation" means the term as defined by 9VAC25-31-10.

"Cropland" means land that is used for the production of grain, oilseeds, silage, or industrial crops not defined as hay or pasture.

"DCR" means the Department of Conservation and Recreation.

"Delivery factor" means the estimated percentage of a total nitrogen or total phosphorus load delivered to tidal waters as determined by the specific geographic location of the nutrient source. For point source discharges the delivery factor accounts for attenuation that occurs during riverine transport between the point of discharge and tidal waters. For nonpoint source loads the delivery factor accounts for attenuation that occurs during riverine transport as well as attenuation between the nutrient source and the edge of the nearest stream. Delivery factors values shall be as specified by the department.

"Department" means the Department of Environmental Quality.

"Director" means the Director of the Department of Environmental Quality or his designee.

"Exchange" means the transaction in which a person buys released nutrient credits produced by a nutrient credit-generating entity.

"Field office technical guide" or "FOTG" means technical guides about conservation of soil, water, air, and related plant and animal resources and are the primary scientific reference for the U.S. Department of Agriculture's Natural Resource Conservation Service. These guides are used in each field office and are localized so that they apply specifically to the geographic area for which they are prepared.

"Hayland" means land that is used to grow a grass, legume, or other plants such as clover or alfalfa, which is cut and dried for feed.

"Highly erodible soils" means land that is defined as highly erodible by the Sodbuster, Conservation Reserve, and Conservation Compliance parts of the Food Security Act of 1985 (Pub. L. No. 99-198) and the Food, Agriculture, Conservation, and Trade Act of 1990 (Pub. L. No. 101-624). Lists of highly erodible and potential highly erodible map units are maintained in NRCS field office technical guide.

"HUC" means the hydrologic unit code.

"Impaired waters" means those waters identified as impaired in the 305(b)/303(d) Water Quality Assessment Integrated Report (see 9VAC25-900-70).

"Implementation plan" means a plan that has been developed to meet the requirements of 9VAC25-900-120 and is submitted as part of the application.

"Invasive plant species" means non-native plant species that are contained on DCR's List of Invasive Alien Plant Species of Virginia (see 9VAC25-900-70).

"Land use conversion" means a change from a more intensive to less intensive land use resulting in nutrient reductions.

"Land use controls" means legal measures or instruments that restrict the activity, use, and access to property.

"Management area" means all contiguous parcels deeded to the same landowner that includes the nutrient credit-generating site within its boundaries. The term contiguous means the same or adjacent parcels that may be divided by public or private right-of-way. The management area does not include publicly owned roads or rights-of-way.

"Mitigation banking instrument" means the legal document for the establishment, operation, and use of a stream or wetland mitigation bank.

"MS4" means a municipal separate storm sewer system as defined in 9VAC25-870-10.

"Non-land use conversion" means practices, except for land use conversion, that are used by a nutrient credit-generating entity to produce nutrient reductions.

"Nonpoint source pollution" means pollution such as sediment, nitrogen, phosphorus, hydrocarbons, heavy metals, and toxics whose sources cannot be pinpointed but rather are washed from the land surface in a diffuse manner by stormwater runoff.

"NRCS" mean the U.S. Department of Agriculture's Natural Resource Conservation Service.

"Nutrient credit" or "credit" means a nutrient reduction that is certified pursuant to this chapter and expressed in pounds of phosphorus and nitrogen either (i) delivered to tidal waters when the credit is generated within the Chesapeake Bay

Watershed or (ii) as otherwise specified when generated in the Southern Rivers watersheds. Nutrient credit does not include point source nitrogen credits or point source phosphorus credits as defined in § 62.1-44.19:13 of the Code of Virginia.

"Nutrient credit-generating entity" or "entity" means an entity that implements practices for the generation of nonpoint source nutrient credits.

"Nutrient reductions" means the reduction in the load of nitrogen and phosphorous nonpoint source pollution.

"Owner" means the Commonwealth or any of its political subdivisions, including but not limited to sanitation district commissions and authorities and any public or private institution, corporation, association, firm, or company organized or existing under the laws of this or any other state or country, or any officer or agency of the United States, or any person or group of persons acting individually or as a group that owns, operates, charters, rents, or otherwise exercises control over or is responsible for any nutrient credit-generating entity.

"Pasture" means land that supports the grazing of domesticated animals for forages.

"Performance standards" means the minimum objectives or specifications required of a particular management practice by the department in order to assure predicted nutrient reductions will be achieved.

"Perpetual nutrient credits" or "perpetual credits" mean credits that are certified as permanent in accordance with this chapter.

"Person" means any individual, corporation, partnership, association, state, municipality, commission, or political subdivision of a state, governmental body, including a federal, state, or local entity as applicable, any interstate body or any other legal entity.

"Potential nutrient credits" means the possible credits generated by a nutrient credit-generating entity as calculated pursuant to 9VAC25-900-110. These potential nutrient credits shall be expressed in terms of the estimated number of phosphorus and nitrogen credits generated.

"Redevelopment" means a project that includes new development on previously developed land.

"Registry" means the online Virginia Nutrient Credit Registry established and maintained by the department in accordance with § 62.1-44.1.19:20 D of the Code of Virginia.

"Released nutrient credit" means credits that the department has determined to be eligible for exchange on the Virginia Nutrient Credit Registry.

"Retrofit" means a project that provides improved nutrient reductions to previously developed land through the implementation of new BMPs or upgrades to existing BMPs.

"Site" means the physical location where the nutrient credit-generating entity and its associated practices, both baseline and credit-generating, are located.

"Site protection instrument" means a legal mechanism approved by the department that provides assurance that the credits will be maintained for the term of the credit.

"Southern Rivers watersheds" means the land areas draining to the following river basins: the Albemarle Sound, the Big Sandy River Basin, the Chowan River Basin, the Clinch-Powell River Basin, the New Holston River Basin (Upper Tennessee), the New River Basin, the Roanoke River Basin, the Yadkin River Basin, or those water bodies draining directly to the Atlantic Ocean.

"Structural BMPs" means any manmade stormwater control measure or feature that requires routine maintenance in order to function or provide the hydrologic, hydraulic, or water quality benefit as designed. Structural practices include, but are not limited to bioretention, infiltration facilities, wet ponds, extended detention, wet and dry swales, permeable pavement, rainwater harvesting, vegetated roofs, underground or surface chambers or filters, and other manufactured treatment devices (MTDs).

"T" means the soil loss tolerance rate as defined by the NRCS.

"Term nutrient credit" or "term credit" means nutrient reduction activities that generate credits for a determined and finite period of at least one year.

"Total maximum daily load" or "TMDL" means the sum of the individual wasteload allocations (WLAs) for point sources, load allocations (LAs) for nonpoint sources, natural background loading, and a margin of safety. TMDLs can be expressed in terms of either mass per time, toxicity, or other appropriate measure. The TMDL process provides for point versus nonpoint source trade-offs. TMDL is not necessarily a daily load but may be expressed in other units of time. For nutrient trading, yearly loads are most often utilized.

"Tributary" means those river basins for which separate tributary strategies were prepared pursuant to § 2.2-218 of the Code of Virginia and includes the Potomac, Rappahannock, York, and James River basins, and the Eastern Coastal Basin, which encompasses the creeks and rivers of the Eastern Shore of Virginia that are west of Route 13 and drain into the Chesapeake Bay. For areas outside of the Chesapeake Bay Watershed, "tributary" includes the following watersheds: Albemarle Sound, Coastal; Atlantic Ocean, Coastal; Big Sandy; Chowan; Clinch-Powell; New Holston (Upper Tennessee); New River; Roanoke; and Yadkin.

"Urban lands" means lands characterized by developed areas with buildings, asphalt, concrete, suburban gardens, and a systematic street pattern. Classes of urban development include residential, commercial, industrial, institutional, transportation, communications, utilities, and mixed urban. Undeveloped land surrounded by developed areas, such as

cemeteries, golf courses, and urban parks is recognized as urban lands.

"VACS BMP Manual" means the Virginia Agricultural Cost Share BMP Manual (see 9VAC25-900-70).

"Virginia Chesapeake Bay TMDL Watershed Implementation Plan," "Watershed Implementation Plan," or "WIP" means the Phase I watershed implementation plan strategy submitted by Virginia and approved by the Environmental Protection Agency (EPA) in December 2010 to meet the nutrient and sediment allocations prescribed in the Chesapeake Bay Watershed TMDL or any subsequent revision approved of EPA (see 9VAC25-900-70).

"Virginia Pollutant Discharge Elimination System permit" or "VPDES permit" means a document issued by the State Water Control Board pursuant to the State Water Control Law authorizing, under prescribed conditions, the potential or actual discharge of pollutants from a point source to surface waters and the use or disposal of sewage sludge.

"Virginia Stormwater Management Program" or "VSMP" means a program to manage the quality and quantity of runoff resulting from land-disturbing activities and includes such items as local ordinances, rules, permit requirements, annual standards and specifications, policies and guidelines, technical materials, and requirements for plan review, inspection, and enforcement, where authorized in the Stormwater Management Act and pursuant to 9VAC25-870, 9VAC25-880, or 9VAC25-890.

"VPA" means Virginia Pollution Abatement.

"VPDES" means Virginia Pollutant Discharge Elimination System.

"VWP" means Virginia Water Protection.

"Water body with perennial flow" means a body of water that flows in a natural or man-made channel year-round during a year of normal precipitation as a result of groundwater discharge or surface runoff. Such water bodies exhibit the typical biological, hydrological, and physical characteristics commonly associated with the continuous conveyance of water.

"Water Quality Guide" means Virginia's Forestry Best Management Practices for Water Quality (see 9VAC25-900-70).

Part II
General Information

9VAC25-900-20. Authority and delegation of authority.

A. This chapter is issued under authority of § 62.1-44.19:20 of the Act.

B. The director may perform any act of the board provided under this regulation except as limited by § 62.1-44.14 of the Code of Virginia.

9VAC25-900-30. Purpose and applicability.

A. The purpose of this chapter is to establish standards and procedures pertaining to the certification of nutrient credits.

B. This chapter applies to all persons who submit an application for and to all persons that receive a certification of nutrient credits from the department in accordance with the Act and this chapter.

C. Nutrient credits from stormwater nonpoint nutrient credit-generating entities in receipt of a Nonpoint Nutrient Offset Authorization for Transfer letter from the department prior to [the effective date of this chapter] shall be considered certified nutrient credits and shall not be subject to further nutrient credit certification requirements or to the credit retirement requirements of this chapter. However, such entities shall be subject to all other provisions of this chapter, including registration under 9VAC25-900-90 and the requirements of Part IV (9VAC25-900-140 et seq.) including inspection, reporting, and enforcement.

9VAC25-900-40. Relationship to other laws and regulations.

A. Specific requirements regarding the use of nutrient credits are found in the following regulations and statutes:

1. Virginia Stormwater Management Program (VSMP) Regulation (9VAC25-870).

a. VSMP Individual Permits for Discharges from Construction Activities. As specified in § 62.1-44.19:21 B of the Act, those applicants required to comply with water quality requirements for land-disturbing activities operating under a construction individual permit issued pursuant to 9VAC25-870 may acquire and use perpetual nutrient credits placed on the registry for exchange.

b. VSMP Individual Permits for Municipal Storm Sewer Systems. As specified in § 62.1-44.19:21 A of the Act, an MS4 permittee may acquire, use, and transfer nutrient credits for purposes of compliance with any wasteload allocations established as effluent limitations in an MS4 individual permit issued pursuant to 9VAC25-870. Such method of compliance may be approved by the department following review of a compliance plan submitted by the permittee that includes the use of nutrient credits and is in accordance with the provisions of § 62.1-44.19:21 A.

2. General VPDES Permit for Discharges of Stormwater from Construction Activities (9VAC25-880). As specified in § 62.1-44.19:21 B of the Act, those applicants required to comply with water quality requirements for land-disturbing activities operating under a general VSMP permit for discharges of stormwater from construction activities issued pursuant to 9VAC50-880 may acquire and use perpetual nutrient credits placed on the registry for exchange.

3. General VPDES Permit for Discharges of Stormwater from Small Municipal Separate Storm Sewer Systems (9VAC25-890). As specified in § 62.1-44.19:21 A of the Act, an MS4 permittee may acquire, use, and transfer nutrient credits for purposes of compliance with any

wasteload allocations established as effluent limitations in an MS4 general permit issued pursuant to 9VAC25-890. Such method of compliance may be approved by the department following review of a compliance plan submitted by the permittee that includes the use of nutrient credits and is in accordance with the provisions of § 62.1-44.19:21 A.

4. Virginia Pollutant Discharge Elimination System (VPDES) Permit Regulation (9VAC25-31). As specified in § 62.1-44.19:21 C of the Act, owners of confined or concentrated animal feeding operations issued individual permits pursuant to 9VAC25-31 may acquire, use, and transfer credits for compliance with any wasteload allocations contained in the provisions of a VPDES permit. Such method of compliance may be approved by the department following review of a compliance plan submitted by the permittee that includes the use of nutrient credits.

5. General Virginia Pollutant Discharge Elimination System (VPDES) Permit for Discharges of Storm Water Associated with Industrial Activity (9VAC25-151). As specified in § 62.1-44.19:21 D of the Act, owners of facilities registered for coverage under 9VAC25-151 for the general VPDES permit may acquire, use, and transfer credits for compliance with any wasteload allocations established as effluent limitations in a VPDES permit. Such method of compliance may be approved by the department following review of a compliance plan submitted by the permittee that includes the use of nutrient credits.

6. General Virginia Pollutant Discharge Elimination System (VPDES) Watershed Permit Regulation for Total Nitrogen and Total Phosphorus Discharges and Nutrient Trading in the Chesapeake Bay Watershed in Virginia (9VAC25-820). Nutrient credits certified pursuant to this chapter may be acquired to offset mass loads of total nitrogen or total phosphorus discharged by new or expanded facilities regulated by 9VAC25-820.

B. This chapter shall not be construed to limit or otherwise affect the authority of the board to establish and enforce more stringent water quality-based effluent limitations for total nitrogen or total phosphorus in permits where those limitations are necessary to protect local water quality. The exchange or acquisition of credits pursuant to this chapter shall not affect any requirement to comply with such local water quality-based limitations.

9VAC25-900-50. Appeal process.

Any person applying to establish a nutrient credit-generating entity or an owner of a nutrient credit-generating entity aggrieved by any action of the department taken in accordance with this chapter, or by inaction of the department, shall have the right to review in accordance with the provisions of the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia).

9VAC25-900-60. Limitations, liability, and prohibitions.

A. The department shall not have responsibility or liability for the performance of practices at a nutrient credit-generating entity evaluated using the procedures established in this chapter.

B. Those persons with whom the department contracts, including those serving as technical evaluators on an advisory committee, are advisors to the department, and the department remains solely responsible for decisions made regarding implementation of this chapter.

C. For the purposes of this chapter, the certification of nutrient credits that are generated from practices funded in part or in whole by federal or state water quality grant funds is prohibited other than controls and practices under § 62.1-44.19:20 B 1 a of the Act; however, establishing baseline as specified in 9VAC25-900-100 may be achieved through the use of such grants.

D. The option to acquire nutrient credits for compliance purposes shall not eliminate any requirement to comply with local water quality requirements.

E. The issuance of a nutrient credit certification under this chapter does not convey any property rights of any sort or any exclusive privilege.

F. The issuance of a nutrient credit certification under this chapter does not authorize any injury to persons or property or invasion of other private rights, or any infringement of state or local law or regulations.

G. Nutrient credit certifications are not transferable except after notice to the department in accordance with 9VAC25-900-180. The department may require modification or revocation and reissuance of nutrient credit certifications to change the name of the owner of the nutrient credit-generating entity and incorporate such other requirements as may be necessary under the State Water Control Law or the Clean Water Act.

H. No person shall offer for exchange nutrient credits except in compliance with the provisions of this chapter.

I. No nutrient credit shall be generated by practices previously implemented to comply with: (i) the requirements for a VPDES (9VAC25-31), VPA (9VAC25-32), VWP (9VAC25-210), or VSMP (9VAC25-870) permit; (ii) erosion and sedimentation control requirements pursuant to 9VAC25-840; or (iii) the requirements of the Chesapeake Bay Preservation Act pursuant to § 62.1-44.15:67-79 of the Code of Virginia.

9VAC25-900-70. Documents and Internet accessible resources.

This chapter refers to documents and Internet accessible resources to be used by applicants in gathering information to be submitted to the department. Therefore, in order to assist the applicants, the citations for the documents and the uniform resource locator (URL) for the Internet resources referenced in this chapter are as follows:

1. Virginia Chesapeake Bay TMDL Watershed Implementation Plan, November 29, 2010, Department of Environmental Quality. Available at the following Internet address:

http://www.deq.virginia.gov/Portals/0/DEQ/Water/TMDL/Baywip/vatmdlwipphase1.pdf.

2. Virginia Agricultural Cost Share BMP Manual, Program Year 2014, July 2013 Department of Conservation and Recreation, Division of Soil and Water Conservation, Richmond, Virginia. Available at the following Internet address:

http://dswcapps.dcr.virginia.gov/htdocs/agbmpman/csmanual.pdf.

3. List of Invasive Alien Plant Species of Virginia, Department of Conservation and Recreation, Division of Natural Heritage, Richmond, Virginia. Available at the following Internet address:

http://www.dcr.virginia.gov/natural_heritage/invsppdflist.shtml.

4. Field Office Technical Guide, Natural Resources Conservation Service, United States Department of Agriculture, Washington, D.C. Available at the following Internet address:

http://efotg.sc.egov.usda.gov/efotg_locator.aspx.

5. 305(b)/303(d) Water Quality Assessment Integrated Report, 2012, Department of Environmental Quality. Available at the following Internet address:

http://www.deq.virginia.gov/Programs/Water/WaterQualityInformationTMDLs/WaterQualityAssessments/2012305(b)303(d)IntegratedReport.aspx.

6. Virginia's Forestry Best Management Practices for Water Quality, Fifth Edition 2011, Department of Forestry. Available at the following Internet address:

http://www.dof.virginia.gov/print/water/BMP/Manual/2011_Manual_BMP.pdf.

Part III
Administrative and Technical Criteria

9VAC25-900-80. Procedure for application for certification of nutrient credits.

A. Application submittal. An applicant requesting certification of nutrient credits shall submit an application to the department. The application shall be in the form required by the department including signature in accordance with 9VAC25-900-130 and shall include the following elements:

1. A brief narrative description of the nutrient credit-generating entity.

2. Contact information for the applicant including name, address, and telephone number.

3. Contact information for the nutrient credit-generating entity, including the entity's mailing address, street address, telephone number, and the contact person's name and email address.

4. Status of the applicant as owner, co-owner, operator, or lessee of the nutrient credit-generating entity or the site on which the entity is located. The applicant shall provide documentation of the applicant's right to exercise control of the nutrient credit-generating entity or the site on which it is located for the purposes of generating and maintaining the proposed nutrient credit-generating entity. If the applicant cannot demonstrate control, those parties who singularly or in conjunction with the applicant exercise control over the nutrient credit-generating entity or the site on which it is located shall be required to jointly apply for nutrient credit certification with the applicant.

5. The name, mailing address, telephone number, and responsibilities of all known contractors responsible for any operational or maintenance aspects of the nutrient credit-generating entity.

6. The number of potential nutrient credits to be generated and supporting information including (i) a description of the baseline practices in place within the management area and the nutrient credit-generating entity's practices that may result in generation of nutrient credits beyond baseline requirements; (ii) the potential nutrient credit calculation including the efficiencies and factors used; and (iii) the associated documentation supporting the potential nutrient credits calculation. Baseline shall be determined in accordance with the requirements of 9VAC25-900-100. The number of potential nutrient credits shall be as calculated in accordance with 9VAC25-900-110.

7. A topographic map or another type of map deemed acceptable by the department that delineates the property boundary of the management area and clearly shows the location of the nutrient credit-generating entity and baseline practices.

8. A description of current site conditions with photos.

9. The 8-digit, 10-digit, and 12-digit HUC in which the nutrient credit-generating entity is located.

10. For land use conversion projects, provide documentation of the condition of the land and land use controls in place as of the date specified in 9VAC25-900-100 E noting any changes in the condition of the land or land use controls since that date.

11. An implementation plan that meets the requirements of 9VAC25-900-120.

12. For structural BMPs, the financial assurance cost estimate calculated pursuant to Part VI (9VAC25-900-230 et seq.).

13. The appropriate fee required pursuant to Part V (9VAC25-900-190 et seq.).

14. The proposed site protection instrument or instruments for perpetual credits.

15. A description of other permits and approvals that may be necessary to operate the nutrient credit-generating entity.

16. A description of any state or federal water quality grants received for water quality actions in the management area.

17. For perpetual credits, notarized proof that all management area property used to generate credits is held with clear title by the owner and free of any unsubordinated liens.

18. A tax map showing the management area and adjacent parcels.

19. Any other information deemed necessary by the department.

B. Administrative completeness review. Upon receiving an application pursuant to subsection A of this section, the department shall conduct an administrative completeness review prior to the technical review and respond within 30 calendar days of application receipt. If the application is not administratively complete, the department shall notify the applicant of the administrative deficiencies. If the application is administratively complete, the department shall notify the applicant that application will be technically reviewed for nutrient credit certification.

C. Public notification. The department shall post a public notification of the proposed nutrient credit-generating entity on its website.

D. Technical review. Once the application is deemed administratively complete, the department shall perform a technical review of the application. As part of the technical review, additional information may be required and the nutrient credit-generating entity and management area may be visited. Additionally, if the department chooses, a certification advisory committee may be convened. Within 90 days of the receipt of an administratively complete application, the department shall notify the applicant of the status of the technical review of the application.

E. Technical completeness. The nutrient credits shall not be certified until the application is administratively and technically complete. An application for nutrient credit certification is technically complete when the department receives an application in accordance with subsection A of this section and the application, and any supplemental information fulfills the application requirements to the department's satisfaction.

F. Nutrient credit certification. The department shall notify the applicant of approval of the nutrient credit certification and provide any applicable conditions required for credit certification including retirement and release of credits in accordance with 9VAC25-900-90, or the department shall notify the applicant that the nutrient credit-generating entity does not qualify for any certified credits pursuant to the requirements of this part.

9VAC25-900-90. Nutrient credit release and registration.

A. Retirement of credits.

1. Pursuant to the requirements of § 62.1-44.19:20 of the Act, 5.0% of the total credits certified will be retired by the department at the time of nutrient credit certification and will not be placed on the registry for exchange.

2. When phosphorus credits are acquired for compliance with 9VAC25-870, the associated nitrogen credits generated by the nutrient credit-generating entity will be retired and removed from the registry by the department.

3. When nitrogen credits are exchanged for purposes other than compliance with 9VAC25-870, the associated phosphorus credits generated by the nutrient-credit entity shall not be available for compliance under 9VAC25-870.

B. Schedule of release of nutrient credits. The department shall establish a schedule for release of credits as follows:

1. For nutrient credit-generating entities using land use conversion, 25% of the credits will be released by the department after the department has verified completion of the conditions of the nutrient credit certification. The remaining 75% of credits will be released by the department after it is satisfied that the implementation plan's performance criteria required pursuant to 9VAC25-900-120 has been achieved.

2. For nutrient credit-generating entities using practices other than land use conversion, the schedule for release of credits will be determined by the department and provided to the applicant with the nutrient credit certification. For entities using structural BMPs, the schedule shall also require, prior to release of credits, the approval of the financial assurance mechanism established pursuant to Part VI (9VAC25-900-230 et seq.).

C. Registration of nutrient credits. Credits will be placed on the registry and classified as term or perpetual credits by the department. The registry will also indicate the number of credits that have been released for exchange. Only credits released by the department are available for exchange. Exchange of a credit released by the department is:

1. Subject to the provisions of § 62.1-44.15:35, 62.1-44.19:15, or 62.1-44.19:21 of the Code of Virginia; and

2. Where necessary to ensure compliance with local water quality requirements, conditioned as follows:

a. Within the Chesapeake Bay Watershed, the exchange of credits within an area subject to an approved local TMDL for total phosphorus or total nitrogen with allocations more stringent than the Chesapeake Bay Watershed TMDL shall be limited to those credits generated upstream of where the discharge reaches impaired waters and within the approved local TMDL watershed.

b. Within the Southern Rivers watersheds, the exchange of credits within an area subject to an approved local

TMDL for total phosphorus or total nitrogen shall be limited to those credits generated upstream of where the discharge reaches impaired waters and within the approved local TMDL watershed.

c. Within an area with waters impaired for dissolved oxygen, benthic community or nutrients but with no approved local TMDL, the exchange of credits shall be limited to those credits generated in accordance with the following hierarchy:

(1) Upstream of where the discharge reaches impaired waters, if credits are available;

(2) Within the same 12-digit HUC, if credits are available;

(3) Within the same 10-digit HUC, if credits are available;

(4) Within the same 8-digit HUC, if credits are available;

(5) Within an adjacent 8-digit HUC within the same tributary, if credits are available; or

(6) Within the same tributary.

The hierarchy of this subdivision shall not apply should it be demonstrated to the department's satisfaction that the water quality impairment is not likely caused by nutrients.

9VAC25-900-100. Establishing baseline.

A. Practices for establishing baseline must be in place prior to the generation of any credits by a nutrient credit-generating entity except in the case of land use conversion as described in subsection E of this section. The practices for establishing baselines, as provided in this section, shall be implemented and properly maintained for each type of operation within the management area. Baselines are applicable statewide for nutrient credit-generating entities including those located in either the Chesapeake Bay Watershed or the Southern Rivers watersheds.

B. Agricultural cropland, hayland, and pastures. The baseline for agricultural management areas are those practices implemented to achieve a level of reduction assigned in the WIP or an approved TMDL. Baselines for cropland, hayland, or pastures within the management area shall be established in accordance with either subdivision 1, 2, or 3 of this subsection.

1. The owner holds a valid Certificate of Resource Management Plan Implementation for the management area that has been issued pursuant to the Resource Management Plans regulation (4VAC50-70).

2. If the owner does not hold a valid Certificate of Resource Management Plan Implementation for the management area, he shall implement the following practices for establishing baseline:

a. Soil conservation. Soil conservation practices for the management area shall be implemented and maintained to achieve a maximum soil loss rate not to exceed "T" and to address gross erosion when it is present as gullies or other severely eroding conditions.

b. Nutrient management. Implementation and maintenance of the nutrient management practices required by the nutrient management plan written by a certified nutrient management planner pursuant to the Nutrient Management Training and Certification Regulations (4VAC50-85).

c. Riparian buffer. A woodland or grass riparian buffer shall be installed and maintained around all water bodies with perennial flow within the management area and shall be installed and maintained along all water bodies with perennial flow bordering the management area. The riparian buffer shall be a minimum width of 35 feet as measured from the top of the channel bank to the edge of the cropland, hayland, or pasture and in accordance with DCR Specifications for NO. FR-3 or DCR Specifications for NO. WQ-1 contained in the VACS BMP Manual.

d. Cover crop. For croplands, cover crops shall be planted to meet the standard planting date and other specifications in accordance with DCR Specifications for NO. SL-8B contained in the VACS BMP Manual. This requirement applies to all croplands where summer annual crops are grown and the summer annual crop receives greater than a total of 50 pounds per acre of nitrogen application from any nutrient source; however, if the cropland is planted to winter cereal crops for harvest in the spring, then cover crops do not need to be planted on these croplands during that production year.

e. Livestock water body exclusion. For pastures or when livestock are present within the management area, livestock exclusion fencing shall be placed around perennial streams, rivers, lakes, ponds, or other water bodies having perennial flow. This exclusionary fencing shall be constructed in accordance with DCR Specification NO. WP-2 contained in the VACS BMP Manual in order to restrict livestock access to the water body. Livestock shall be provided with an alternative watering source. The livestock exclusion fencing shall be placed at least 35 feet from the top of the channel bank and this exclusion zone shall contain the riparian buffer required by subdivision 2 c of this subsection. Access points for livestock watering or crossing over a water body shall be a hardened surface constructed to DCR Specifications for NO. WP-2 contained in the VACS BMP Manual and shall be fenced to limit livestock access to the water body at the crossing point. Ponds that have been specifically built for the purpose of livestock watering and that do not have perennial flow through an overflow pipe or spillway are not required to meet the provisions of this subdivision.

3. The department may approve a load-based baseline determination equivalent to full implementation of the practices identified in subdivision 2 of this subsection.

C. Agricultural animal feeding operations. Baselines for agricultural animal feeding operations within the management area shall be established in accordance with either subdivision 1 or 2 of this subsection:

1. The animal feeding operation within the management area has a valid VPDES or VPA permit in compliance with the board's regulations.

2. For animal feeding operations excluded from or not required to hold a VPDES or VPA permit under the board's regulations, the practices for establishing baseline shall be implemented and properly maintained as required in this subdivision 2.

a. Implementation and maintenance of the nutrient management practices required by the nutrient management plan written by a certified nutrient management planner pursuant to the Nutrient Management Training and Certification Regulations (4VAC50-85).

b. For animal feeding operations, except confined poultry operations, a storage facility designed and operated to prevent point source discharges of pollutants to state waters except in the case of a storm event greater than a 25-year/24-hour storm and to provide adequate waste storage capacity to accommodate periods when the ground is frozen or saturated, periods when land application of nutrients should not occur due to limited or nonexistent crop nutrient uptake, and periods when physical limitations prohibit the land application of waste shall be implemented and maintained.

c. For confined poultry operations, storage of poultry waste according to the nutrient management plan and in a manner that prevents contact with surface water and groundwater. Poultry waste that is stockpiled outside of the growing house for more than 14 days shall be kept in a facility or at a location that provides adequate storage. Adequate storage management practices shall meet the following minimum requirements:

(1) The poultry waste shall be covered to protect it from precipitation and wind.

(2) Stormwater shall not run onto or under the area where the poultry waste is stored.

(3) The ground surface of the poultry waste storage area shall have a minimum of two feet separation distance to the seasonal high water table. If poultry waste is stored in an area where the seasonal high groundwater table lies within two feet of the ground surface, the storage area shall be underlain by a low-permeability, hard-surfaced barrier such as concrete or asphalt.

(4) For poultry waste that is not stored inside or under a roofed structure, the storage area must be at least 100 feet from any surface water, intermittent drainage, wells, sinkholes, rock outcrops, and springs.

D. Urban practices. Baselines for urban development are applicable to the entire management area. Achievement of baseline for new development, redevelopment, or retrofits to existing development shall be required prior to generation of credits. These baselines are:

1. For new development and redevelopment, baseline shall be achieved through compliance with the post-construction water quality design criteria requirements of the Virginia Stormwater Management Program (VSMP) Regulation under 9VAC25-870-63. Additionally, for development in a locality with a local stormwater management design criteria more stringent than 9VAC25-870-63, baselines shall be achieved through compliance with the local stormwater management ordinance.

2. For retrofits within the Chesapeake Bay Watershed, baseline shall be at a level necessary to achieve the nutrient reduction assigned in the urban sector of the WIP or the approved local TMDL, whichever is more stringent.

3. For retrofits within the Southern Rivers watersheds and within a watershed with an approved TMDL with total phosphorus or total nitrogen allocations, baselines shall be at a level necessary to achieve reductions of the approved TMDL. For all other retrofits within the Southern Rivers watersheds, baseline shall be achieved through compliance with the post-construction water quality design criteria requirements for development on prior developed lands pursuant to 9VAC25-870-63 A 2.

E. Land use conversions. Baselines for land use conversion shall be established using the preconversion land use. The preconversion land use shall be based on the land use as of (i) July 1, 2005, for a nutrient credit-generating entity located within the Chesapeake Bay Watershed; (ii) the date of the approved TMDL for a nutrient credit-generating entity located within a TMDL watershed but not within the Chesapeake Bay Watershed; or (iii) July, 1, 2009, for a nutrient credit-generating entity not within an approved TMDL watershed or the Chesapeake Bay Watershed.

F. Other nutrient credit-generating entities. The department shall establish baselines for other nutrient credit-generating entities not otherwise regulated by subsections B through E of this section. The practices necessary for establishing baseline at these other nutrient credit-generating entities shall be in accordance with the requirements of the WIP or the approved TMDL and shall utilize the best available scientific and technical information regarding the practices.

9VAC25-900-110. Credit calculation procedures.

A. Pursuant to this section, the applicant shall calculate the potential nutrient credits generated by the practices implemented at the nutrient credit-generating entity. The applicable delivery factors, dependent upon the tributary in which the nutrient credit-generating entity is located, shall be applied when calculating the potential credits generated.

B. For agricultural practices, except land use conversion, the potential nutrient credits shall be calculated using removal efficiencies for practices approved by the department. In the Chesapeake Bay Watershed, these practices shall be approved by the department based on the efficiencies assigned by the Chesapeake Bay Program. In the Southern Rivers watersheds, these practices shall be approved by the department based on submitted calculations and demonstrations. The standards and specifications for implementation of the practices will be established by the department and shall be in accordance with the VACS BMP Manual or the FOTG, as applicable.

C. For urban practices, the potential nutrient credits shall be calculated using the applicable removal efficiencies pursuant to 9VAC25-870-65 or using the best available scientific and technical information available at the time of nutrient credit certification as approved by the department. Limitations on potential nutrient credits from certain BMPs are:

1. In the Chesapeake Bay Watershed, nutrient load reductions from practices in place prior to July 1, 2005, may not be used to generate credits.

2. In the Southern Rivers watersheds, nutrient load reductions from practices in place prior to July 1, 2009, may not be used to generate credits.

D. For land use conversions, conversion of land to a more intensive land use activity will not generate nutrient credits. The number of potential nutrient credits shall be determined by calculating the nutrient credits per acre and multiplying that number by the total acreage that will undergo land use conversion. The nutrient credits per acre is equal to the amount calculated by subtracting the load per acre of nutrient nonpoint source pollution for the proposed land use after conversion from the load per acre for the preconversion land use. The values used for the loadings per acre in this calculation shall be based on the applicable loading levels provided in the WIP or the approved TMDL. The preconversion land use shall be based on the land use as of the date specified in 9VAC25-900-100 E. The load per acre for the preconversion land use shall reflect the implementation of any applicable baseline practices necessary to comply with 9VAC25-900-100 B, C, and D. No credits shall be generated from the conversion of land within 35 feet of a water body with perennial water flow as measured from the top of the channel bank.

E. For a practice not previously approved by the department, the department will perform a case-by-case review in order to calculate the number of potential nutrient credits generated. The owner shall submit the removal efficiency calculation information for the practice and the calculation of the potential number of credits generated using that efficiency. The department may also request that the submittal include requirements for demonstration projects, the collection of sufficient data to evaluate the results, and any other information the department deems necessary to determine the validity of the credits.

9VAC25-900-120. Implementation plan.

A. The implementation plan submitted pursuant to 9VAC25-900-80 shall provide information detailing how the nutrient credit-generating entity will generate credits for the term of the credits. The implementation plan will include the applicable information as required in subsections B through I of this section.

B. For all nutrient credit-generating entities, the implementation plan shall include:

1. An operation and maintenance plan that provides a description and schedule of operation and maintenance requirements and detailed written specifications and process diagrams for the practices used at the nutrient credit-generating entity. The plan must be adhered to for the term of the credits and shall include a description of site management activities to be performed after meeting all performance standards to ensure long-term sustainability of the site.

2. The performance standards that shall be used to evaluate whether the nutrient credit-generating entity is generating credits as calculated in 9VAC25-900-110.

3. Applicable requirements for the project required pursuant to Part IV (9VAC25-900-140 et seq.).

C. For nutrient credit-generating entities utilizing managed afforestation land use conversion, the implementation plan shall also include:

1. A project plan submitted in the form required by the department and prepared by a person trained in (i) forestry management, (ii) nutrient management, or (iii) other applicable land management training that includes an understanding of whole land management planning. The project plan shall include, but is not limited to (i) methods for invasive plant species control and eradication if woody invasive plant species impacts 5.0% or more of the nutrient credit-generating entity's acreage; (ii) a requirement that any harvesting of timber shall adhere to best management practices as set forth by DOF's Water Quality Guide and any other applicable local, state, or federal laws or requirements; (iii) the land management goals; (iv) a statement that no fertilizer is to be used on the nutrient credit-generating entity's land conversion acreage for the term of the credit generated; (v) a planting plan to include size, species, and spacing of trees; and (vi) any planting phases planned for the project if the area will not be planted all at one time, but will be planted in different phases. Additionally, if timbering is planned within the land conversion area, a copy of the timbering plan shall be submitted to the department at least 90 days prior to the occurrence of any land disturbance or timbering.

2. Provisions for planting forests to achieve an initial survival density of a minimum of 400 woody stems per acre including any noninvasive volunteers. Survival of planted deciduous trees shall not be established until the

start of the second complete growing season following planting. Survival of planted evergreen trees may be established after completion of the first complete growing season following planting.

3. A description of agricultural baseline requirements implemented in accordance with 9VAC50-900-100 B and C that apply to any remaining portions of the management area that are not undergoing land use conversion.

4. Performance standards and reporting procedures demonstrating ongoing compliance with the baseline requirements of 9VAC25-900-100 B and C.

D. For nutrient credit-generating entities utilizing natural succession land use conversion, the implementation plan shall also include provisions for:

1. Forests to achieve an initial density of a minimum of 400 noninvasive woody stems per acre.

2. Invasive plant species control and eradication if woody invasive plant species impacts 5.0% or more of the nutrient credit-generating entity's acreage.

3. A description of agricultural baseline requirements implemented in accordance with 9VAC25-900-100 B and C that apply to any remaining portions of the management area not undergoing land use conversion.

4. Performance standards for demonstrating ongoing compliance with the agricultural baseline requirements of 9VAC25-900-100 B and C.

E. For nutrient credit-generating entities utilizing other land use conversion not subject to either subsection C, D, or G of this section, the implementation plan shall also include:

1. Description of the land use conversion project and its implementation and maintenance criteria.

2. Description of the applicable baseline practices implemented in accordance with 9VAC25-900-100 for the management area including the nutrient credit-generating entity.

3. Performance standards and reporting procedures demonstrating ongoing compliance with the baseline practices requirements of 9VAC25-900-100.

F. For nutrient credit-generating entities utilizing non-land use conversion agricultural practices, the implementation plan shall also include:

1. A description of the entire management area. This description shall include (i) the acreage and use including descriptions for the proposed practices of the nutrient credit-generating entity and baseline area or areas; (ii) water features including all streams, ponds, lakes, and wetlands; (iii) environmentally sensitive sites as defined in 4VAC50-85-10; (iv) areas with highly erodible soils; and (v) the current agricultural operations, crops, or animal facilities.

2. Copies of the current nutrient management plans developed by a certified nutrient management planner and approved by the department and any soil conservation plans completed by a certified conservation planner.

3. Information on the location and status of all existing and proposed BMPs including implementation schedules, lifespan, and maintenance procedures for each BMP that constitutes the baseline requirements.

G. For nutrient credit-generating entities utilizing existing wetland and stream mitigation projects pursuant to § 62.1-44.15:23 of the Code of Virginia, the implementation plan shall also include:

1. A copy of the approved mitigation banking instrument.

2. A plan clearly delineating and labeling areas to be considered for credit conversion.

3. A spreadsheet or table listing each labeled area. For each labeled area, the table shall include:

a. The type of eligible land use conversion;

b. The acreage of the area;

c. The available mitigation credits;

d. The potential nutrient credits; and

e. The ratio of mitigation credits to nutrient credits.

4. Documentation that complies with the department-approved procedure to ensure credits are not used for both wetland or stream credit and nutrient credit purposes. This documentation shall include the approval by the mitigation banking Interagency Review Team.

H. For nutrient credit-generating entities utilizing urban practices, the implementation plan shall also include:

1. A description of the contributing drainage area (CDA) for the proposed nutrient credit-generating entity's BMP. This description shall include (i) the acreage and land covers (e.g., impervious, forest or open space, managed turf, etc.); (ii) water features including all streams, ponds, lakes, and wetlands; (iii) identification of all impaired waters and approved TMDLs; and (iv) identification/mapping of the soil types within the CDA, by USDA hydrological soil group.

2. A list of all of the current urban nutrient management plans developed by a certified nutrient management planner and being implemented within the CDA.

3. Information on the location and description of existing BMPs within the CDA. For BMPs that constitute the baseline requirements include implementation schedules, lifespan, and maintenance procedures.

4. For development and redevelopment projects, the implementation plan shall include the erosion and sediment control plan and the stormwater management plan developed in accordance 9VAC25-870.

5. For retrofits, the implementation plan shall include relevant credit calculations and documentation as deemed appropriate by the department.

I. For other types of activities or projects not presented in subsections C through H of this section, the implementation plan shall include information as deemed appropriate by the department in order to evaluate the credits for nutrient credit certification.

9VAC25-900-130. Signature requirements.

A. All applications for certification of nutrient credits shall be signed as follows:

1. For a corporation, the application shall be signed by a responsible corporate officer. For the purpose of this section, a responsible corporate officer means a president, secretary, treasurer, or vice-president of the corporation in charge of a principal business function or any other person who performs similar policy-making or decision-making functions for the corporation or the manager of the nutrient credit-generating entity provided the manager is authorized to make management decisions that govern the operation of the entity;

2. For a partnership or sole proprietorship, the application shall be signed by a general partner or the proprietor, respectively; or

3. For a municipality, state, federal, or other public agency, the application shall be signed by either a principal executive officer or ranking elected official. For purposes of this section, a principal executive officer of a federal agency includes the chief executive officer of the agency or a senior executive officer having responsibility for the overall operations of a principal geographic unit of the agency.

B. All reports required by this chapter and other information requested by the department shall be signed by a person described in subsection A of this section or by a duly authorized representative of that person. A person is a duly authorized representative only if:

1. The authorization is made in writing by a person described in subsection A of this section;

2. The authorization specifies either an individual or a position having responsibility for the overall operation of the entity; and

3. The written authorization is submitted to the department.

C. If an authorization under subsection B of this section is no longer accurate because a different individual or position has responsibility for the overall operation of the entity, a new authorization satisfying the requirements of subsection B of this section shall be submitted to the department prior to or together with any reports or information to be signed by an authorized representative.

D. Any person signing a document under subdivision A or B of this section shall certify that all submittals are true, accurate, and complete to the best of his knowledge and belief.

Part IV
Compliance and Enforcement

9VAC25-900-140. Inspections and information to be furnished.

A. The owner of the nutrient credit-generating entity shall allow the director or an authorized representative, including an authorized contractor acting as a representative of the department, upon presentation of credentials, to:

1. Enter the management area including the premises where the nutrient credit-generating entity is located and where records are kept in accordance with this chapter or the nutrient credit certification. Records to be retained include the approved implementation plan, operations and maintenance plan, and, if required, confirmation of financial assurance documents.

2. Have access to and copy, at reasonable times, any records that must be kept under the conditions of this chapter, the approved plans listed in subdivision A 1 of this section, or as otherwise required by the nutrient credit certification. The owner will make available any records requested by the department that detail nutrient credit-generating entity operations, status, records of transactions or other actions that demonstrate the status of credits and operations of the nutrient credit-generating entity including records required to be kept under any implementation plan, operations and maintenance plan, or financial assurance documents;

3. Inspect at reasonable times any entities, equipment, practices, or operations regulated or required under the provisions of this chapter, the approved plans listed in subdivision A 1 of this section, or as otherwise required by the nutrient credit certification; and

4. Sample or monitor at reasonable times, for the purposes of assuring compliance with the provisions of this chapter, the nutrient credit certification, or as otherwise authorized by state law or regulation.

B. For purposes of this section, the time for inspection shall be deemed reasonable during regular business hours. Nothing in this section shall make an inspection unreasonable during an emergency when applicable.

C. The owner of the nutrient credit-generating entity shall furnish to the department, within a reasonable time, any information that the department may request to determine (i) whether cause exists for suspension of nutrient credit exchange, modifying, revoking and recertifying, or terminating nutrient credit certification or (ii) compliance with the provisions of this chapter or the implementation plan, operations and maintenance plan, or financial assurance approved under this chapter. The department may require the owner of the nutrient credit-generating entity to furnish, upon request, such plans, specifications, and other pertinent information as may be necessary to determine the effect of the operation of the nutrient credit-generating entity on the

quality of state waters, or such other information as may be necessary to accomplish the purposes of the law. The owner of the nutrient credit-generating entity shall also furnish to the department, upon request, copies of records required to be kept under the provisions of this chapter or the nutrient credit certification including the approved implementation plan, operations and maintenance plan, or proof of financial assurance records.

9VAC25-900-150. Recordkeeping and reporting.

A. The owner of the nutrient credit-generating entity shall maintain all records relevant to the management, operations, and maintenance of the nutrient credit-generating entity, including copies of all reports required by this chapter, the nutrient credit certification or the implementation plan, operations and maintenance plan, or financial assurance approved under this chapter. Records of all data used to complete the application for certification of nutrient credits shall be kept. All records shall be maintained for at least five years following the final exchange of any credits. This period of retention shall be extended automatically during the course of any unresolved litigation regarding the regulated activity or regarding control standards applicable to the owner of the nutrient credit-generating entity, or as requested by the board.

B. All applications, reports, or information submitted to the department shall be signed and certified as required by 9VAC25-900-130.

C. Reporting requirements.

1. The owner of the nutrient credit-generating entity shall give advance notice to the department as soon as possible of any planned physical alterations or additions to the entity when the alteration or addition could change the amount of nutrient reductions generated.

2. The owner of the nutrient credit-generating entity shall give advance notice to the department of any planned changes in the entity that may result in noncompliance with the Act, this chapter, or the nutrient credit certification.

3. Reports of compliance or noncompliance with, or any progress reports on achieving conditions specified in the nutrient credit certification shall be submitted no later than 14 days following each schedule date.

4. Where the owner of the nutrient credit-generating entity becomes aware that incorrect information has been submitted in an application for nutrient credit certification or in any report to the department, the owner shall promptly submit the corrected information.

5. Each owner shall submit an annual report on the status of the nutrient credit-generating entity operations including credit-generating practices, confirmation of the continued implementation and maintenance of practices required to establish baseline in accordance with 9VAC25-900-100, and an up-to-date credit ledger detailing credits available for exchange, credits exchanged, and associated purchaser information. This report shall contain recent photographs of any structural BMPs implemented to achieve baseline or for nutrient credit generation and it shall cover the period from July 1 through June 30 of each year. The report shall be submitted annually by August 15.

6. Exchange of credits shall be recorded on the registry. The exchange of credits by the owner of the nutrient credit-generating entity shall be reported to the department within 14 calendar days of the date of the exchange. This report shall include:

a. The identification for the credits exchanged;

b. The name of and contact information for the buyer;

c. The name of the seller;

d. The amount of credits exchanged; and

e. If applicable, the name of the facility and the associated permit number that shall use the purchased credits.

9VAC25-900-160. Enforcement and penalties.

The board may enforce the provisions of this chapter utilizing all applicable procedures under the State Water Control Law.

9VAC25-900-170. Suspension of credit exchange.

A. If the department tentatively decides to suspend the ability of an owner of a nutrient credit-generating entity to exchange credits, the department shall issue a notice of its tentative decision to the owner. If the department determines that suspension is appropriate, it will also remove the ability for the owner to show credits for exchange on the registry. The ability to exchange credits shall remain suspended until such time as the owner brings the nutrient credit-generating entity into compliance with this chapter and the nutrient credit certification to the department's satisfaction.

B. The following are causes for the department to suspend the exchange of credits:

1. Noncompliance by the owner of the nutrient credit-generating entity with any condition of the nutrient credit certification or any plans approved under or required by the nutrient credit certification or this chapter;

2. Failure of the owner of the nutrient credit-generating entity to disclose fully all relevant material facts or, the misrepresentation of any relevant material facts in applying for certification of nutrient credits or in any other report or document required under the law, this chapter, the nutrient credit certification, or any plans approved or required under the nutrient credit certification;

3. A change in any condition that results in a temporary or permanent elimination of the best management practices approved as part of the nutrient credit certification; or

4. There exists a material change in the basis on which the nutrient credit certification was issued that requires either a temporary or permanent elimination of activities controlled by the nutrient credit certification necessary to protect

human health or the environment; however, credit quantities established using the best available scientific and technical information at the time of certification may not be reduced.

9VAC25-900-180. Nutrient credit certification transfer, modification, revocation and recertification, or termination.

A. Nutrient credit certifications may be modified, revoked and reissued, or terminated either at the request of the party holding the certification or upon the department's initiative for cause. The filing of a request by the holder of the nutrient credit certification for a modification, revocation and reissuance, or termination of a certification, or a notification of planned changes or anticipated noncompliance with regulatory requirements does not stay any condition of a nutrient credit certification.

B. If the department decides that a request for modification, revocation and reissuance, or termination is not justified, it shall send the requester a brief response giving a reason for the decision.

C. If the department tentatively decides to modify or revoke and reissue a nutrient credit certification, it may request the submission of a new application.

D. If the department tentatively decides to terminate a nutrient credit certification and the owner of the nutrient credit-generating entity objects, the department shall issue a notice of intent to terminate and shall contemporaneously notify any known buyers of the entity's nutrient credits of its intent to terminate.

E. A certification of nutrient credits may be modified, revoked and reissued, or terminated for cause.

1. Causes for modification. The following are causes for modification, revocation, and reissuance of a certification of nutrient credits:

a. There are material and substantial alterations or additions to the nutrient credit-generating entity that occurred after certification of nutrient credits and that justify the application of conditions that are different or absent in the existing nutrient credit certification.

b. The department has received new technical information that would have justified the application of different conditions at the time of issuance; however, credit quantities established using the best available scientific and technical information at the time of certification may not be reduced.

c. The department determines good cause exists for modification of milestones within the nutrient credit certification.

d. To correct technical mistakes, such as errors in calculation, or mistaken interpretations of law made in determining nutrient credit certification conditions.

e. The department has received notification of a proposed transfer of ownership of the nutrient credit-generating entity.

2. Causes for termination. The following are causes for terminating a nutrient credit certification during its term or for denying an application for certification of nutrient credits after notice and opportunity for a hearing:

a. The owner of the nutrient credit-generating entity has violated any regulation or order of the board or department, any provision of the law, or any order of a court, where such violation results in a release of harmful substances into the environment or poses a substantial threat of release of harmful substances into the environment or presents a hazard to human health or the violation is representative of a pattern of serious or repeated violations that, in the opinion of the department, demonstrates the owner's disregard for or inability to comply with applicable laws, regulations, or requirements;

b. Noncompliance by the owner of the nutrient credit-generating entity with any condition of the nutrient credit certification or any plans approved under or required by the nutrient credit certification or this chapter;

c. Failure of the owner of the nutrient credit-generating entity to disclose fully all relevant material facts or the misrepresentation of any relevant material facts in applying for a certification of nutrient credits or in any other report or document required under the law, this chapter, the nutrient credit certification, or any plans approved or required under the nutrient credit certification;

d. A determination that the credit-generating activity endangers human health or the environment and can only be regulated to acceptable levels by modification or termination of the nutrient credit certification;

e. A change in any condition that results in a permanent elimination of any of the best management practices approved as part of the nutrient credit certification; or

f. There exists a material change in the basis on which the nutrient credit certification was issued that requires either a temporary or a permanent elimination of activities controlled by the nutrient credit certification necessary to protect human health or the environment; however, credit quantities established using the best available scientific and technical information at the time of certification may not be reduced.

g. Failure of the owner of the nutrient credit-generating entity to operate and maintain the required baseline practices throughout the management area.

F. Except as provided in subsection G of this section, a nutrient credit certification may be transferred to a new owner or operator only if the certification has been modified or revoked and reissued to identify the new owner or operator

and incorporate such other requirements as may be necessary under the Act and this chapter.

G. As an alternative to transfers under subsection F of this section, any certification of nutrient credits may be automatically transferred if:

1. The current holder of the certification of nutrient credits notifies the department at least 30 days in advance of the proposed transfer date in subdivision 2 of this subsection;

2. The notice includes a written agreement between the existing and new owners containing a specific date for transfer of responsibility, coverage, and liability for the nutrient credit-generating entity between them; and

3. If the department does not notify the existing holder of the certification of nutrient credits and the proposed holder of its intent to modify or revoke and reissue the nutrient credit certification within the 30 days of receipt of the holder's notification of transfer, the transfer is effective on the date specified in the agreement mentioned in subdivision 2 of this subsection.

H. The department shall follow the applicable procedures in this chapter when terminating any nutrient credit certification, except when the baseline or nutrient reduction practices used at a nutrient credit-generating entity are permanently terminated or eliminated the department may then terminate the nutrient credit certification by notice to the owner of the nutrient credit-generating entity. Termination by notice shall be effective 30 days after notice is sent, unless the owner objects within that time. If the owner objects during that period, the department shall follow the applicable procedures for termination under this section.

Part V
Fees

9VAC25-900-190. Purpose and applicability of fees.

A. The purpose of this part is to establish a schedule of fees collected by the department in the support of its programs under this chapter and as permitted under the Act.

B. This part applies to all persons who submit an application for a certification of nutrient credits in accordance with 9VAC25-900-80. The fees shall be assessed in accordance with this part.

9VAC25-900-200. Determination of application fee amount.

A. Each nutrient credit-generating entity application and each nutrient credit-generating entity modification application is a separate action and shall be assessed a separate fee. The amount of such fees is determined on the basis of this section.

B. Perpetual nutrient credit certifications.

1. An applicant for certification of perpetual nutrient credits is assessed a base fee as shown in Table 1 of 9VAC25-900-220 A.

2. An applicant is assessed a supplementary fee based on the number of potential nutrient credits of phosphorus generated in addition to the base fee specified in subdivision 1 of this subsection. The supplementary fees are shown in Table 1 of 9VAC25-900-220 A.

3. Modifications of approved perpetual nutrient credit certifications will be assessed the base fee only unless the modifications generate additional perpetual credits then a supplementary fee based on the number of additional potential nutrient credits of phosphorus will be assessed in addition to the base fee as specified in subdivision 2 of this subsection.

4. The total fee (base fee plus supplementary fee) shall not exceed $10,000. If the calculated fee is greater than $10,000 then the applicant shall only pay $10,000.

C. Term nutrient credit certifications.

1. An applicant for certification of term nutrient credits is assessed a base fee plus a supplementary fee based on the number of potential term credits and the requested term of those credits as shown in Table 2 of 9VAC25-900-220 A.

2. A modification of an approved term nutrient credit certification is assessed a base fee plus a supplementary fee based on the number of term credits and the requested term of those credits as shown in Table 2 of 9VAC25-900-220A.

3. A renewal will be assessed a base fee plus a supplementary fee based on the number of renewing term credits as shown in Table 3 of 9VAC25-900-220 A if there are (i) no changes to the site or practices that were submitted with the previously approved nutrient credit certification application; (ii) the renewal application submitted is an exact duplicate of the application for the previously approved nutrient credit certification; and (iii) the application is submitted at least 60 days prior to the end date of the term credits for which renewal is sought. If the renewal application is submitted less than 60 days prior to the end date of the term credits, the application shall be deemed a new application and shall be assessed a fee as provided in subdivision 1 of this subsection.

4. The total fee (base fee plus supplementary fee) shall not exceed $10,000. If the calculated fee is greater than $10,000 then the applicant shall only pay $10,000.

9VAC25-900-210. Payment of application fees.

A. Due date. All application fees are due on the day of application and must accompany the application.

B. Method of payment. Fees shall be paid by check, draft, or postal money order made payable to "Treasurer of Virginia" and shall be sent to the Department of Environmental Quality, Receipts Control, P.O. Box 1104, Richmond, VA 23218. When the department is able to accept electronic payments, payments may be submitted electronically.

C. Incomplete payments. All incomplete payments will be deemed nonpayments.

D. Late payment. Pursuant to 9VAC25-900-80, no applications will be deemed to be complete until the department receives proper payment.

9VAC25-900-220. Application fee schedule.

A. Fees.

Table 1. Perpetual Nutrient Credits Certification Application Fees

Base Fee	$3,000
Supplementary Fees – Total Number of Perpetual Phosphorus Credits (X)	
X < 30	$1,000
30 < X ≤ 60	$3,000
60 < X < 90	$5,000
X > 90	$7,000

Table 2. Term Nutrient Credits Certification Application Fees

Base Fee	$3,000
Supplementary Fees	$/(Credit*Term Years)
1st 100 term nutrient credits (1 to 100)	$4.00
2nd 100 term nutrient credits (101 to 200)	$3.00
3rd 100 term nutrient credits (201 to 300)	$2.00
4th 100 term nutrient credits (> 300)	$1.00

Table 3. Renewal Term Nutrient Credits Certification Application Fees

Base Fee	$1,000
Supplementary Fees	$/(Credit*Term Years)
1st 100 term nutrient credits (1 to 100)	$4.00
2nd 100 term nutrient credits (101 to 200)	$3.00
3rd 100 term nutrient credits (201 to 300)	$2.00
4th 100 term nutrient credits (> 300)	$1.00

B. Illustrative examples.

1. Example 1. The applicant is submitting an application for nutrient credit certification of a nutrient credit-generating entity that will generate perpetual credits. The number of potential perpetual credits calculated is 150. The required fee is calculated as follows:

Base fee	$3,000
Supplementary fee for 150 perpetual P credits	+$7,000
Total fee	=$10,000

2. Example 2. The applicant is submitting an application for nutrient credit certification of a nutrient credit-generating entity that generated credits with a five-year term. The number of potential nutrient credits calculated is 275. The required fee is calculated as follows:

Base fee	$3,000
Supplementary fee for 1 to 100 credits	+(100*5*$4)=$2,000
Supplementary fee for 101 to 200 credits	+(100*5*$3)=$1,500
Supplementary fee for 201 to 275 credits	+ (75*5*$2)= $750
Total fee	= $7,250

3. Example 3. The applicant is submitting a renewal application for annual credits generated at a nutrient credit-generating entity for a five-year term. The number of annual credits being renewed for another term is 165. The required fee is calculated as follows:

Base fee	$1,000
Supplementary fee for 1 to 100 credits	+(100*5*$4)=$2,000
Supplementary fee for 101 to 200 credits	+(65*5*$3)=$975
Total fee	= $3,975

Part VI
Financial Assurance

9VAC25-900-230. Financial assurance applicability.

A. An owner of a nutrient credit-generating entity that utilizes structural BMPs for the generation of perpetual credits shall submit and maintain financial assurance in accordance with this part. The financial assurance mechanism shall be submitted to and approved by the department prior to the release of credits.

B. An owner of a nutrient credit-generating entity that utilizes structural BMPs for the generation of term credits with terms that exceed one year shall submit and maintain financial assurance in accordance with this part. The financial assurance mechanism shall be submitted to and approved by the department prior to the release of credits. For the purposes

of this part, term credit shall refer to credit with a term greater than one year.

C. An owner of a nutrient credit-generating entity that utilizes structural BMPs for the generation of credits with a term of one year shall not be required to provide financial assurance.

D. When the nutrient credits are generated or used by a locality, authority, utility, sanitation district, or owner operating an MS4 or a point source permitted under 9VAC25-870, the existing tax or rate authority may be used to provide evidence of the financial assurance required pursuant to this part. The locality, authority, utility, sanitation district, or owner shall certify as a condition of their application that such tax or rate authority will be used to ensure an adequate supply of credits to meet the entity's obligation, whether by continued operation and maintenance of the structural BMPs at the nutrient credit-generating entity or by other means.

9VAC25-900-240. Suspension of nutrient credit exchange.

Failure to provide or maintain adequate evidence of financial assurance in accordance with this part shall be cause for the department to suspend the exchange of credits in accordance with 9VAC25-900-170 or terminate the nutrient credit certification in accordance with 9VAC25-900-180.

9VAC25-900-250. Cost estimates for perpetual and term credit nutrient credit-generating entities.

A. The owner of a nutrient credit-generating entity shall prepare for approval by the department a detailed written cost estimate providing the cost of either repairing or restoring and operating and maintaining any structural BMPs generating perpetual nutrient credits or term nutrient credits with a term of greater than one year. This written cost estimate shall be submitted as part of the application in accordance with 9VAC25-900-80 and shall include:

1. For structural BMPs generating perpetual nutrient credits, the cost estimate shall equal the estimated cost for either repairing or restoring the structural BMPs plus the cost for five years of operation and maintenance of the structural BMPs in accordance with the implementation plan.

2. For structural BMPs generating term nutrient credits, the cost estimate shall equal the full cost for either repairing or restoring the structural BMPs plus the cost for the operation and maintenance of the structural BMPs in accordance with the implementation plan for the term of the credits or for five years, whichever is less.

3. The cost estimate shall be based on and include the costs of hiring a third party to either repair or restore and operate and maintain the structural BMPs generating nutrient credits. The third party may not be either a parent corporation or subsidiary of the owner.

B. For a nutrient credit-generating entity generating perpetual credit from structural BMPs, the cost estimate shall be reviewed for sufficiency by the department at least once every five years.

9VAC25-900-260. Financial assurance requirements for term credits.

A. For a nutrient credit-generating entity generating term credits with a term of greater than one year, the owner shall demonstrate financial assurance using any one or a combination of the mechanisms specified in 9VAC25-900-290 through 9VAC25-900-330.

B. The financial assurance mechanism or mechanisms shall provide funding for the full amount of the cost estimate at all times.

C. The financial assurance mechanism or mechanisms used to provide evidence of the financial assurance shall ensure that the funds necessary will be available whenever they are needed.

D. The owner shall provide continuous financial assurance coverage for the term credit nutrient credit-generating entity in accordance with this part until released by the department.

E. After submittal of a complete financial assurance mechanism, the department shall notify the owner of the tentative decision to approve or reject the financial assurance mechanism.

9VAC25-900-270. Financial assurance requirements for perpetual credits.

A. Subject to the requirements and limitations outlined in this section, the owner shall demonstrate financial assurance for the perpetual credit nutrient credit-generating entity using any one or combination of the mechanisms specified in 9VAC25-900-290 through 9VAC25-900-330.

B. The financial assurance mechanism or mechanisms shall provide funding for the full amount of the cost estimate at all times.

C. The owner may only establish or continue to use insurance, as outlined in 9VAC25-900-330, to demonstrate financial assurance for that portion of the total cost estimate that does not include credits that have been exchanged. On an annual basis, the owner shall either establish or increase the noninsurance mechanism or mechanisms outlined in 9VAC25-900-290 through 9VAC25-900-320 in an amount to be determined in accordance with the formula below:

CE/TCIAS * CEDAAP

where:

CE = Cost Estimate

TCIAS = Total Number of Credits Initially Available for Exchange

CEDAAP = Number of Credits Exchanged During the Applicable Annual Period

D. The owner shall establish or increase the mechanism or mechanisms as required by subsection C no later than 30 days after the current anniversary date of the nutrient credit

certification. The applicable annual period for credits exchanged is the one culminating on the anniversary date of the nutrient credit certification.

E. The financial assurance mechanisms used to provide evidence of the financial assurance shall ensure that the funds necessary will be available whenever they are needed.

F. After submittal of a complete financial assurance mechanism, the department shall notify the owner of the tentative decision to approve or reject the financial assurance mechanism.

9VAC25-900-280. Allowable financial mechanisms.

Subject to the limitations and requirements outlined in 9VAC25-900-260 and 9VAC25-900-270, an owner of nutrient credit-generating entity using structural BMPs to generate term or perpetual nutrient credits may use any one or combination of mechanisms listed in 9VAC25-900-290 through 9VAC25-900-330 to meet the financial assurance requirements of this part.

9VAC25-900-290. Trust.

A. An owner may satisfy the requirements of this part by establishing a trust fund that conforms to the requirements of this section and by submitting an originally signed triplicate of the trust agreement to the director. The owner shall also place a copy of the trust agreement into the nutrient credit-generating entity's operating record. The trustee for the trust fund shall be a bank or financial institution that has the authority to act as a trustee and whose trust operations are regulated and examined by a state or federal agency.

B. Payments into the trust fund shall be made by the owner whenever necessary under the requirements of 9VAC25-900-260 or 9VAC25-900-270.

C. During any annual period when a payment into the fund is necessary under the requirements outlined in 9VAC25-900-260 and 9VAC25-900-270, the owner must submit the following information to the director no later than the anniversary date of the initial approval by the department of the release of credits for exchange:

1. The calculation for determining the appropriate payment amount into the trust; and

2. A statement from the trustee indicating the amount of the currently required deposit into the trust fund and the subsequent balance of the fund.

D. The owner shall compare the cost estimate with the trustee's most recent annual valuation of the trust fund:

1. Annually, at least 60 days prior to the anniversary date of the initial approval by the department of the release of credits for exchange. If the value of the fund is less than the amount of the cost estimate, the owner shall, by the anniversary date of the initial approval by the department of the release of credits for exchange, deposit a sufficient amount into the fund so that its value after payment at least equals the amount of the cost estimate, or obtain other financial assurance as specified in this part to cover the difference. If the value of the trust fund is greater than the total amount of the cost estimate, the owner may submit a written request to the director for release of the amount that is in excess of the cost estimate; and

2. Whenever the cost estimate changes. If the value of the fund is less than the amount of the new cost estimate, the owner shall, within 60 days of the change in the cost estimate, deposit a sufficient amount into the fund so that its value after payment at least equals the amount of the new estimate, or obtain other financial assurance as specified in this part to cover the difference. If the value of the trust fund is greater than the total amount of the cost estimate, the owner may submit a written request to the director for release of the amount that is in excess of the cost estimate.

E. Subject to the limitations and requirements outlined in 9VAC25-900-260 and 9VAC25-900-270, if the owner substitutes other financial assurance as specified in this part for all or part of the trust fund, the owner may submit a written request to the director for release of the amount in excess of the current cost estimate covered by the trust fund.

F. Within 60 days after receiving a request from the owner for release of funds as described in subsections E and G of this section, the director shall instruct the trustee to release to the owner such funds as the director deems appropriate, if any, in writing.

G. The director shall agree to terminate the trust when:

1. The owner substitutes alternate financial assurance as specified in this part; or

2. The director notifies the owner that the owner is no longer required by this part to maintain financial assurance for the operation and maintenance or replacement of the nutrient credit-generating entity's structural BMPs.

H. The trust agreement shall be worded as described in 9VAC25-900-350, except that instructions in parentheses are to be replaced with the relevant information and the parantheses deleted, and the trust agreement shall be accompanied by a formal certification of acknowledgment and Schedules A and B.

9VAC25-900-300. Surety bond.

A. An owner may satisfy the requirements of this part by obtaining a surety bond that conforms to the requirements of this section and by submitting an originally signed duplicate of the bond to the department. The surety company issuing the bond shall be licensed to operate as a surety in the Commonwealth of Virginia and be among those listed as acceptable sureties on federal bonds in the latest Circular 570 of the U.S. Department of the Treasury.

B. Under the terms of the bond, the surety shall become liable on the bond obligation when the owner fails to perform as guaranteed by the bond.

C. The bond shall guarantee that the owner or any other authorized person shall:

1. Operate and maintain or replace any structural BMPs for achieving nutrient reductions at the nutrient credit-generating entity in question and in accordance with the nutrient credit certification;

2. Operate and maintain or replace any structural BMPs following an order to do so that has been issued by the department or by a court.

D. The owner shall compare the cost estimate with the penal sum of the bond:

1. Annually, at least 60 days prior to the anniversary date of the initial approval by the department of the release of credits for exchange. If the penal sum of the bond is less than the amount of the cost estimate, the owner shall, by the anniversary date of the initial approval by the department of the release of credits for exchange, increase the penal sum of the bond so that its value at least equals the amount of the cost estimate, or obtain other financial assurance as specified in this part to cover the difference. If the penal sum of the bond is greater than the total amount of the cost estimate, the owner may submit a written request to the director for permission to reduce the penal sum of the bond to the amount of the cost estimate; and

2. Whenever the cost estimate changes. If the penal sum of the bond is less than the amount of the new cost estimate, the owner shall, within 60 days of the change in the cost estimate, increase the penal sum of the bond so that its value at least equals the amount of the new estimate, or obtain other financial assurance as specified in this part to cover the difference. If the penal sum of the bond is greater than the total amount of the cost estimate, the owner may submit a written request to the director for permission to reduce the penal sum of the bond to the amount of the cost estimate.

E. The surety bond shall guarantee that the owner shall provide alternate evidence of financial assurance as specified in this part within 60 days after receipt by the department of a notice of cancellation of the bond from the surety.

F. The bond shall remain in force for its term unless the surety sends written notice of cancellation by certified mail to the owner and to the department. Cancellation cannot occur, however, during the 120 days beginning on the date of receipt of the notice of cancellation by the department as shown on the signed return receipt. The surety shall provide written notification to the department by certified mail no less than 120 days prior to the expiration date of the bond that the bond will expire and the date the bond will expire.

G. The department shall cash the surety bond if it is not replaced 60 days prior to expiration with alternate evidence of financial assurance acceptable to the department or if the owner fails to fulfill the conditions of the bond.

H. The department shall return the original surety bond to the surety for termination when:

1. The owner substitutes acceptable alternate evidence of financial assurance; or

2. The department notifies the owner that the owner is no longer required by this part to maintain evidence of financial assurance for operation and maintenance or replacement of the structural BMPs at the nutrient credit-generating entity.

I. The surety bond shall be worded as described in 9VAC25-900-350, except that instructions in parentheses are to be replaced with the relevant information and the parentheses deleted.

9VAC25-900-310. Letter of credit.

A. An owner may satisfy the requirements of this part by obtaining an irrevocable standby letter of credit that conforms to the requirements of this section and by submitting an originally signed duplicate of the letter of credit to the department. The issuing institution shall be an entity that has the authority to issue letters of credit in the Commonwealth of Virginia and whose letter-of-credit operations are regulated and examined by a federal agency or the Virginia State Corporation Commission.

B. The letter of credit shall be irrevocable and issued for a period of at least one year. The letter of credit shall provide that the expiration date will be automatically extended for a period of at least one year. If the issuing institution decides not to extend the letter of credit beyond the current expiration date, it shall, at least 120 days before the expiration date, notify both the owner and the department by certified mail of that decision. The 120-day period will begin on the date of receipt of letter of credit's notice of cancellation by the department as shown on the signed return receipt. If the letter of credit is canceled by the issuing institution, the owner shall obtain alternate evidence of financial assurance to be in effect prior to the expiration date of the letter of credit.

C. The owner shall compare the cost estimate with the face amount of the letter of credit:

1. Annually, at least 60 days prior to the anniversary date of the initial approval by the department of the release of credits for exchange. If the face amount of the letter of credit is less than the amount of the cost estimate, the owner shall, by the anniversary date of the initial approval by the department of the release of credits for exchange, increase the face amount of the letter of credit so that its value at least equals the amount of the cost estimate, or obtain other financial assurance as specified in this part to cover the difference. If the face amount of the letter of credit is greater than the total amount of the cost estimate, the owner may submit a written request to the director for permission to reduce the face amount of the letter of credit to the amount of the cost estimate; and

2. Whenever the cost estimate changes. If the face amount of the letter of credit is less than the amount of the new cost estimate, the owner shall, within 60 days of the change in the cost estimate, increase the face amount of the letter of credit so that its value at least equals the amount of the new estimate or obtain other financial assurance as specified in this part to cover the difference. If the face amount of the letter of credit is greater than the total amount of the cost estimate, the owner may submit a written request to the director for permission to reduce the face amount of the letter of credit to the amount of the cost estimate.

D. The issuing institution may cancel the letter of credit only if alternate evidence of financial assurance acceptable to the department is substituted as specified in this part or if the owner is released by the department from the requirements of financial assurance.

E. The department shall cash the letter of credit when:

1. The issuing institution has provided proper notification, as outlined in subsection B of this section, of its intent not to renew the letter of credit, and the owner has not, within 30 days prior to expiration, replaced the letter of credit with alternate evidence of financial assurance acceptable to the department; or

2. The owner has failed to operate and maintain or replace the nutrient credit-generating entity's structural BMPs in accordance with this chapter and the nutrient credit certification.

F. The department shall return the original letter of credit to the issuing institution for termination when:

1. The owner substitutes acceptable alternate evidence of financial assurance; or

2. The department notifies the owner that the owner is no longer required by this part to maintain evidence of financial assurance for the structural BMPs at his nutrient credit-generating entity.

G. The letter of credit shall be worded as described in 9VAC25-900-350, except that instructions in parentheses are to be replaced with the relevant information and the parentheses deleted.

9VAC25-900-320. Certificate of deposit.

A. An owner may satisfy the requirements of this chapter, wholly or in part, by obtaining a certificate of deposit and assigning all rights, title, and interest in the certificate of deposit to the department, conditioned so that the owner shall operate and maintain or replace the structural BMPs at the nutrient credit-generating entity. The issuing institution shall be an entity that has the authority to issue certificates of deposit in the Commonwealth of Virginia and whose operations are regulated and examined by a federal agency or the Virginia State Corporation Commission. The owner must submit the originally signed assignment and the originally signed certificate of deposit, if applicable, to the department.

B. The amount of the certificate of deposit shall be at least equal to the approved cost estimate. The owner shall maintain the certificate of deposit and assignment until such time as the owner is released by the department from financial assurance.

C. The owner shall be entitled to demand, receive, and recover the interest and income from the certificate of deposit as it becomes due and payable as long as the market value of the certificate of deposit used continues to at least equal the amount of the current approved cost estimate.

D. The department shall cash the certificate of deposit if the owner has failed to operate and maintain or replace his nutrient credit-generating entity's structural BMPs in accordance with this chapter and the nutrient credit certification.

E. Whenever the approved cost estimate increases to an amount greater than the amount of the certificate of deposit, the owner shall, within 60 days of the increase, cause the amount of the certificate of deposit to be increased to an amount at least equal to the new estimate or obtain another certificate of deposit to cover the increase.

F. The department shall return the original assignment and certificate of deposit, if applicable, to the issuing institution for termination when:

1. The owner substitutes acceptable alternate evidence of financial assurance as specified in this part; or

2. The department notifies the owner that the owner is no longer required to maintain evidence of financial assurance for the structural BMPs.

G. The assignment shall be worded as described in 9VAC25-900-350, except that instructions in parentheses shall be replaced with the relevant information and the parentheses deleted.

9VAC25-900-330. Insurance.

A. An owner may demonstrate financial assurance for replacement costs and operation and maintenance by obtaining insurance that conforms to the requirements of this section. The insurance shall be effective before the credits are released by the department for exchange. The insurer must be licensed pursuant to Chapter 10 (§ 38.2-1000 et seq.) of Title 38.2 of the Code of Virginia. The owner shall provide the department with an original signed copy of the insurance policy. The department shall be listed as an additional insured on the policy, but the department shall not be obligated for payment of the premium in any manner.

B. The insurance policy shall guarantee that funds will be available to fund the replacement of the structural BMPs and reasonable and necessary costs for the operation and maintenance of the structural BMPs.

C. The insurance policy shall be issued and maintained for a face amount at least equal to the current cost estimate for applicable costs for replacement and operation and maintenance. The term face amount means the total amount the insurer is obligated to pay under the policy. Actual

payments by the insurer will not change the face amount although the insurer's future liability will be lowered by the amount of the payments.

D. The insurance policy shall provide that the insurer shall pay for the replacement and operation and maintenance of the structural BMPs. Justification and documentation of the expenditures must be submitted to and approved by the director. Requests for payment will be granted by the insurer only if the remaining value of the policy is sufficient to cover the remaining costs of replacement and operation and maintenance of the structural BMP, or if the director approves the payment. The insurer shall notify the director when a payment has been made.

E. Each policy shall contain a provision allowing assignment of the policy to a successor owner. Such assignment may be conditional upon consent of the insurer, provided that such consent is not unreasonably refused.

F. The insurance policy shall provide that the insurer may not cancel, terminate, or fail to renew the policy except for failure to pay the premium. The automatic renewal of the policy shall, at a minimum, provide the insured with the option of renewal at the face amount of the expiring policy. If there is a failure to pay the premium, the insurer may cancel the policy by sending notice of cancellation by certified mail to the owner and to the department 120 days in advance of cancellation. Within 60 days of receipt of notice from the insurer that it does not intend to renew the policy, the owner shall obtain alternate financial assurance and submit it to the department.

G. The owner may cancel the insurance policy only if alternate financial assurance is substituted as specified in this part, or if the owner is no longer required to demonstrate financial responsibility.

H. Within 10 days after commencement of a voluntary or involuntary proceeding under Title 11 (Bankruptcy) of the United States Code, naming an owner as debtor, the owner shall notify the director by certified mail of such commencement.

I. The wording of the insurance endorsement shall be identical to the wording specified in 9VAC25-900-350. ACORD Certificates of Insurance are not valid proof of insurance.

9VAC25-900-340. Incapacity of financial providers or owner.

A. An owner that fulfills the requirements of this part by obtaining a trust fund, a letter of credit, a surety bond, or an insurance policy shall be deemed to be without the required financial assurance in the event of bankruptcy of the trustee or issuing institution, or a suspension or revocation of the authority of the trustee institution to act as trustee or of the institution issuing a surety bond, letter of credit, or insurance policy to issue such mechanisms. The owner or operator shall establish other financial assurance within 60 days of such event.

B. An owner shall notify the director by certified mail of the commencement of a voluntary or involuntary proceeding under Title 11 (Bankruptcy) of the United States Code, naming the owner or operator as debtor, within 10 days after commencement of the proceeding. A guarantor of a corporate guarantee as specified in 9VAC20-70-220 shall make such a notification if he is named as debtor, as required under the terms of the corporate guarantee.

9VAC25-900-350. Wording of the financial assurance mechanism.

A. The wording of the financial assurance mechanisms shall be as provided in this section.

B. Wording of trust agreements.

(NOTE: Instructions in parentheses are to be replaced with the relevant information and the parentheses deleted.)

TRUST AGREEMENT

Trust agreement, the "Agreement," entered into as of (date) by and between (name of the owner), a (State) (corporation, partnership, association, proprietorship), the "Grantor," and (name of corporate trustee), a (State corporation) (national bank), the "Trustee."

Whereas, the State Water Control Board has established certain regulations applicable to the Grantor, requiring that the owner of a nutrient credit-generating entity must provide assurance that funds will be available when needed for (operation and maintenance and/or replacement of the entity,

Whereas, the Grantor has elected to establish a trust to provide (all or part of) such financial assurance for the entity identified herein,

Whereas, the Grantor, acting through its duly authorized officers, has selected the Trustee to be the trustee under this agreement, and the Trustee is willing to act as trustee,

Now, therefore, the Grantor and the Trustee agree as follows:

Section 1. Definitions. As used in this Agreement:

A. The term "fiduciary" means any person who exercises any power of control, management, or disposition or renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of this trust fund, or has any authority or responsibility to do so, or who has any authority or responsibility in the administration of this trust fund.

B. The term "Grantor" means the owner who enters into this Agreement and any successors or assigns of the Grantor.

C. The term "Trustee" means the Trustee who enters into this Agreement and any successor Trustee.

Section 2. Identification of Entity and Cost Estimates. This Agreement pertains to entity(ies) and cost estimates identified on attached Schedule A.

(NOTE: On Schedule A, for each entity list, as applicable, name, address, and the current operation and maintenance and or replacement cost estimates, or portions thereof, for which financial assurance is demonstrated by this Agreement.)

Section 3. Establishment of Fund. The Grantor and the Trustee hereby establish a trust fund, the "Fund," for the benefit of the Department of Environmental Quality, Commonwealth of Virginia. The Grantor and the Trustee intend that no third party have access to the Fund except as herein provided. The Fund is established initially as property consisting of cash or securities, which are acceptable to the Trustee, described in Schedule B attached hereto. Such property and any other property subsequently transferred to the Trustee is referred to as the fund, together with all earnings and profits thereon, less any payments or distributions made by the Trustee pursuant to this Agreement. The Fund will be held by the Trustee, IN TRUST, as hereinafter provided. The Trustee undertakes no responsibility for the amount or adequacy of, nor any duty to collect from the Grantor, any payments to discharge any liabilities of the Grantor established by the Commonwealth of Virginia's Department of Environmental Quality.

Section 4. Payment for (operation and maintenance and/or replacement). The Trustee will make such payments from the Fund as the Department of Environmental Quality, Commonwealth of Virginia will direct, in writing, to provide for the payment of the costs of (operation and maintenance and/or replacement)) of the entity covered by this Agreement. The Trustee will reimburse the Grantor or other persons as specified by the Department of Environmental Quality, Commonwealth of Virginia, from the Fund for (operation and maintenance and/or replacement) expenditures in such amounts as the Department of Environmental Quality will direct, in writing. In addition, the Trustee will refund to the Grantor such amounts as the Department of Environmental Quality specifies in writing. Upon refund, such funds will no longer constitute part of the Fund as defined herein.

Section 5. Payments Comprising the Fund. Payments made to the Trustee for the fund will consist of cash or securities acceptable to the Trustee.

Section 6. Trustee Management. The Trustee will invest and reinvest the principal and income of the Fund and keep the Fund invested as a single fund, without distinction between principal and income, in accordance with investment guidelines and objectives communicated in writing to the Trustee from time to time by the Grantor, subject, however, to the provisions of this Section. In investing, reinvesting, exchanging, selling and managing the Fund, the Trustee or any other fiduciary will discharge his duties with respect to the trust fund solely in the interest of the beneficiary and with the care, skill, prudence, and diligence under the circumstances then prevailing which persons of prudence, acting in a like capacity and familiar with such matters, would use in the conduct of any enterprise of a like character and with like aims; except that:

A. Securities or other obligations of the Grantor, or any other owner of the entity, or any of their affiliates as defined in the Investment Company Act of 1940, as amended, 15 USC § 80a-2(a), will not be acquired or held, unless they are securities or other obligations of the federal or a state government;

B. The Trustee is authorized to invest the Fund in time or demand deposits of the Trustee, to the extent insured by an agency of the federal or state government; and

C. The Trustee is authorized to hold cash awaiting investment or distribution uninvested for a reasonable time and without liability for the payment of interest thereon.

Section 7. Commingling and Investment. The Trustee is expressly authorized in its discretion:

A. To transfer from time to time any or all of the assets of the Fund to any common, commingled or collective trust fund created by the Trustee in which the Fund is eligible to participate subject to all of the provisions thereof, to be commingled with the assets of other trusts participating herein. To the extent of the equitable share of the Fund in any such commingled trust, such commingled trust will be part of the Fund; and

B. To purchase shares in any investment company registered under the Investment Company Act of 1940, 15 USC § 80a-1 et seq., or one which may be created, managed, underwritten, or to which investment advice is rendered or the shares of which are sold by the Trustee. The Trustees may vote such shares in its discretion.

Section 8. Express Powers of Trustee. Without in any way limiting the powers and discretions conferred upon the Trustee by the other provisions of this Agreement or by law, the Trustee is expressly authorized and empowered:

A. To sell, exchange, convey, transfer or otherwise dispose of any property held by it, by private contract or at public auction. No person dealing with the Trustee will be bound to see to the application of the purchase money or to inquire into the validity or expediency of any such sale or other dispositions;

B. To make, execute, acknowledge and deliver any and all documents of transfer and conveyance and any and all other instruments that may be necessary or appropriate to carry out the powers herein granted;

C. To register any securities held in the fund in its own name or in the name of a nominee and to hold any security in bearer form or in book entry, or to combine certificates representing such securities with certificates of the same issue held by the Trustee in other fiduciary capacities, or to deposit or arrange for the deposit of such securities in a qualified central depository even though, when so deposited, such securities may be merged and held in bulk in the name of the nominee of such depository with other securities deposited therein by

another person, or to deposit or arrange for the deposit of any securities issued by the United States government, or any agency or instrumentality thereof with a Federal Reserve Bank, but the books and records of the Trustee will at all times show that all such securities are part of the Fund;

D. To deposit any cash in the fund in interest-bearing accounts maintained or savings certificates issued by the Trustee, in its separate corporate capacity, or in any other banking institution affiliated with the Trustee, to the extent insured by an agency of the Federal or State government; and

E. To compromise or otherwise adjust all claims in favor of or against the Fund.

Section 9. Taxes and Expenses. All taxes of any kind that may be assessed or levied against or in respect of the Fund and all brokerage commissions incurred by the Fund will be paid from the Fund. All other expenses incurred by the Trustee in connection with the administration of this Trust, including fees for legal services rendered to the Trustee, the compensation of the Trustee to the extent not paid directly by the Grantor, and all other proper charges and disbursements of the Trustee will be paid from the Fund.

Section 10. Annual Valuation. The Trustee will annually, at the end of the month coincident with or preceding the anniversary date of establishment of the Fund, furnish the Grantor and to the director of the Department of Environmental Quality, Commonwealth of Virginia, a statement confirming the value of the Trust. Any securities in the Fund will be valued at market value as of no more than 30 days prior to the date of the statement. The failure of the Grantor to object in writing to the Trustee within 90 days after the statement has been furnished to the Grantor and the director of the Department of Environmental Quality, Commonwealth of Virginia will constitute a conclusively binding assent by the Grantor, barring the Grantor from asserting any claim or liability against the Trustee with respect to matters disclosed in the statement.

Section 11. Advice of Counsel. The Trustee may from time to time consult with counsel, who may be counsel to the Grantor, with respect to any question arising as to the construction of this Agreement or any action to be taken hereunder. The Trustee will be fully protected, to the extent permitted by law, in acting upon the advice of counsel.

Section 12. Trustee Compensation. The Trustee will be entitled to reasonable compensation for its services as agreed upon in writing from time to time with the Grantor.

Section 13. Successor Trustee. The Trustee may resign or the Grantor may replace the Trustee, but such resignation or replacement shall not be effective until the Grantor has appointed a successor trustee and this successor accepts the appointment. The successor trustee shall have the same powers and duties as those conferred upon the Trustee hereunder. Upon acceptance of the appointment by the successor trustee, the Trustee will assign, transfer and pay over to the successor trustee the funds and properties then constituting the Fund. If for any reason the grantor cannot or does not act in the event of the resignation of the Trustee, the Trustee may apply to a court of competent jurisdiction for the appointment of a successor trustee or for instructions. The successor trustee and the date on which he assumes administration of the trust will be specified in writing and sent to the Grantor, the director of the Department of Environmental Quality, Commonwealth of Virginia, and the present trustees by certified mail 10 days before such change becomes effective. Any expenses incurred by the Trustee as a result of any of the acts contemplated by this section will be paid as provided in Section 9.

Section 14. Instructions to the Trustee. All orders, requests and instructions by the Grantor to the Trustee will be in writing, signed by such persons as are designated in the attached Exhibit A or such other designees as the Grantor may designate by amendment to Exhibit A. The Trustee will be fully protected in acting without inquiry in accordance with the Grantor's orders, requests and instructions. All orders, requests, and instructions by the Director of the Department of Environmental Quality, Commonwealth of Virginia, to the Trustee will be in writing, signed by the Director and the Trustee will act and will be fully protected in acting in accordance with such orders, requests and instructions. The Trustee will have the right to assume, in the absence of written notice to the contrary, that no event constituting a change or a termination of the authority of any person to act on behalf of the Grantor or the Commonwealth of Virginia's Department of Environmental Quality hereunder has occurred. The Trustee will have no duty to act in the absence of such orders, requests and instructions from the Grantor and/or the Commonwealth of Virginia's Department of Environmental Quality, except as provided for herein.

Section 15. Notice of Nonpayment. The Trustee will notify the Grantor and the Director of the Department of Environmental Quality, Commonwealth of Virginia, by certified mail within 10 days following the expiration of the 30-day period after the anniversary of the establishment of the Trust, if no payment is received from the Grantor during that period. After the pay-in period is completed, the Trustee is not required to send a notice of nonpayment.

Section 16. Amendment of Agreement. This Agreement may be amended by an instrument in writing executed by the Grantor, the Trustee, and the Director of the Department of Environmental Quality, Commonwealth of Virginia, or by the Trustee and the Director of the Department of Environmental Quality, Commonwealth of Virginia, if the Grantor ceases to exist.

Section 17. Irrevocability and Termination. Subject to the right of the parties to amend this Agreement as provided in Section 16, this Trust will be irrevocable and will continue until terminated at the written agreement of the Grantor, the Trustee, and the Director of the Department of Environmental Quality, Commonwealth of Virginia, or by the Trustee and

the Director if the Grantor ceases to exist. Upon termination of the Trust, all remaining trust property, less final trust administration expenses, will be delivered to the Grantor.

Section 18. Immunity and Indemnification. The Trustee will not incur personal liability of any nature in connection with any act or omission, made in good faith, in the administration of this Trust, or in carrying out any directions by the Grantor or the Director of the Department of Environmental Quality, Commonwealth of Virginia, issued in accordance with this Agreement. The Trustee will be indemnified and saved harmless by the Grantor or from the Trust Fund, or both, from and against any personal liability to which the Trustee may be subjected by reason of any act or conduct in its official capacity, including all expenses reasonably incurred in its defense in the event the Grantor fails to provide such defense.

Section 19. Choice of Law. This Agreement will be administered, construed and enforced according to the laws of the Commonwealth of Virginia.

Section 20. Interpretation. As used in the Agreement, words in the singular include the plural and words in the plural include the singular. The descriptive headings for each section of this Agreement will not affect the interpretation of the legal efficacy of this Agreement.

In witness whereof the parties have caused this Agreement to be executed by their respective officers duly authorized and their corporate seals to be hereunto affixed and attested as of the date first above written. The parties below certify that the wording of this Agreement is substantively identical to the wording specified in 9VAC25-900-350 B, as such regulations were constituted on the date shown immediately below.

(Signature of Grantor)

By: (Title) (Date)

Attest:

(Title) (Date)

(Seal)

(Signature of Trustee)

By

Attest:

(Title)

(Seal) (Date)

Certification of Acknowledgment:

COMMONWEALTH OF VIRGINIA

STATE OF _____

CITY/COUNTY OF _____

On this date, before me personally came (owner) to me known, who being by me duly sworn, did depose and say that she/he resides at (address), that she/he is (title) of (corporation), the corporation described in and which executed the above instrument; that she/he knows the seal of said corporation; that the seal affixed to such instrument is such corporate seal; that it was so affixed by order of the Board of Directors of said corporation, and that she/he signed her/his name thereto by like order.

(Signature of Notary Public)

C. Wording of surety bond guaranteeing performance or payment.

(NOTE: instructions in parentheses are to be replaced with the relevant information and the parentheses deleted.)

PERFORMANCE OR PAYMENT BOND

Date bond executed: _____

Effective date: _____

Principal: (legal name and business address) _____

Type of organization: (insert "individual," "joint venture," "partnership," or "corporation") _____

State of incorporation: _____

Surety: (name and business address) _____

Name, address, and (operation and maintenance and/or replacement) cost estimate for the entity: _____

Penal sum of bond: $ _____

Surety's bond number: _____

Know all men by these present, That we, the Principal and Surety hereto are firmly bound to the Department of Environmental Quality, Commonwealth of Virginia, (hereinafter called the Department) in the above penal sum for the payment of which we bind ourselves, our heirs, executors, administrators, successors and assigns, jointly and severally; provided that, where the Surety(ies) are corporations acting as co-sureties, we, the Sureties, bind ourselves in such sum "jointly and severally" only for the purpose of allowing a joint action or actions against any or all of us, and for all other purposes each Surety binds itself, jointly and severally with the Principal, for the payment of each sum only as is set forth opposite the name of such Surety, but if no limit of liability is indicated, the limit of liability shall be the full amount of the penal sum.

Whereas, said Principal is required to have from the Department of Environmental Quality, Commonwealth of Virginia, in order to own or operate the, nutrient credit-generating entity identified above, and

Whereas, said Principal is required to provide financial assurance for (operation and maintenance and/or replacement) of the entity as a condition of an order issued by the department,

Now, therefore the conditions of this obligation are such that if the Principal shall faithfully perform (operation and maintenance and/or replacement), whenever required to do so, of the entity identified above in accordance with the order or the (operation and maintenance and/or replacement) submitted to receive and other requirements of as such plan

and may be amended or renewed pursuant to all applicable laws, statutes, rules, and regulations, as such laws, statutes, rules, and regulations may be amended,

Or, if the Principal shall faithfully perform (operation and maintenance and/or replacement) following an order to begin (operation and maintenance and/or replacement) issued by the Commonwealth of Virginia's Department of Environmental Quality or by a court, or following a notice of termination of the permit,

Or, if the Principal shall provide alternate financial assurance as specified in the Department's regulations and obtain the director's written approval of such assurance, within 90 days of the date notice of cancellation is received by the Director of the Department of Environmental Quality from the Surety, then this obligation will be null and void, otherwise it is to remain in full force and effect for the life of the nutrient credit-generating entity identified above.

The Surety shall become liable on this bond obligation only when the Principal has failed to fulfill the conditions described above. Upon notification by the Director of the Department of Environmental Quality, Commonwealth of Virginia, that the Principal has been found in violation of the requirements of the Department's regulations, the Surety must either perform (operation and maintenance and/or replacement) in accordance with the approved plan and other requirements or forfeit the (operation and maintenance and/or replacement) amount guaranteed for the nutrient credit-generating entity to the Commonwealth of Virginia.

Upon notification by the Director of the Department of Environmental Quality, Commonwealth of Virginia, that the Principal has been found in violation of an order to begin operation and maintenance and/or replacement) the Surety must either perform (operation and maintenance and/or replacement) in accordance with the order or forfeit the amount of the (operation and maintenance and/or replacement) guaranteed for the nutrient credit-generating entity to the Commonwealth of Virginia.

The Surety hereby waives notification of amendments to the operation and maintenance and/or replacement, orders, applicable laws, statutes, rules, and regulations and agrees that such amendments shall in no way alleviate its obligation on this bond.

For purposes of this bond, (operation and maintenance and/or replacement) shall be deemed to have been completed when the Director of the Department of Environmental Quality, Commonwealth of Virginia, determines that the conditions of the approved plan have been met.

The liability of the Surety shall not be discharged by any payment or succession of payments hereunder, unless and until such payment or payments shall amount in the aggregate to the penal sum of the bond, but the obligation of the Surety hereunder shall not exceed the amount of said penal sum unless the Director of the Department of Environmental Quality, Commonwealth of Virginia, should prevail in an action to enforce the terms of this bond. In this event, the Surety shall pay, in addition to the penal sum due under the terms of the bond, all interest accrued from the date the Director of the Department of Environmental Quality, Commonwealth of Virginia, first ordered the Surety to perform. The accrued interest shall be calculated at the judgment rate of interest pursuant to § 6.2-302 of the Code of Virginia.

The Surety may cancel the bond by sending written notice of cancellation to the owner and to the Director of the Department of Environmental Quality, Commonwealth of Virginia, provided, however, that cancellation cannot occur (1) during the 120 days beginning on the date of receipt of the notice of cancellation by the director as shown on the signed return receipt; or (2) while an enforcement action is pending.

The Principal may terminate this bond by sending written notice to the Surety, provided, however, that no such notice shall become effective until the Surety receives written authorization for termination of the bond by the Director of the Department of Environmental Quality, Commonwealth of Virginia.

In witness whereof, the Principal and Surety have executed this Performance Bond and have affixed their seals on the date set forth above.

The persons whose signatures appear below hereby certify that they are authorized to execute this surety bond on behalf of the Principal and Surety and I hereby certify that the wording of this surety bond is substantively identical to the wording specified in 9VAC25-900-350 C as such regulations were constituted on the date shown immediately below.

Principal

Signature(s): _____

Name(s) and Title(s): (typed) _____

Corporate Surety

Name and Address: _____

State of Incorporation: _____

Liability Limit: $ ___

Signature(s): _____

Name(s) and Title(s): (typed) _____

Corporate Seal:

D. Wording of irrevocable standby letter of credit.

(NOTE: Instructions in parentheses are to be replaced with the relevant information and the parentheses deleted.)

IRREVOCABLE STANDBY LETTER OF CREDIT

Director

Department of Environmental Quality

P.O. Box 1105

Richmond, Virginia 23218

Dear (Sir or Madam):

We hereby establish our Irrevocable Letter of Credit No..... in your favor at the request and for the account of (owner's name and address) up to the aggregate amount of (in words) U.S. dollars $____, available upon presentation of

1. Your sight draft, bearing reference to this letter of credit No_____ together with

2. Your signed statement declaring that the amount of the draft is payable pursuant to regulations issued under the authority of the Department of Environmental Quality, Commonwealth of Virginia.

The following amounts are included in the amount of this letter of credit: (Insert the nutrient credit-generating entity name and address, and the operation and maintenance and/or replacement cost estimate, or portions thereof, for which financial assurance is demonstrated by this letter of credit.)

This letter of credit is effective as of (date) and will expire on (date at least one year later), but such expiration date will be automatically extended for a period of (at least one year) on (date) and on each successive expiration date, unless, at least 120 days before the current expiration date, we notify you and (owner or operator's name) by certified mail that we decide not to extend the Letter of Credit beyond the current expiration date. In the event you are so notified, unused portion of the credit will be available upon presentation of your sight draft for 120 days after the date of receipt by you as shown on the signed return receipt or while a compliance procedure is pending, whichever is later.

Whenever this letter of credit is drawn on under and in compliance with the terms of this credit, we will duly honor such draft upon presentation to us, and we will pay to you the amount of the draft promptly and directly.

I hereby certify that I am authorized to execute this letter of credit on behalf of (issuing institution) and I hereby certify that the wording of this letter of credit is substantively identical to the wording specified in 9VAC25-900-350 D as such regulations were constituted on the date shown immediately below.

Attest:

(Print name and title of official of issuing institution) (Date)

(Signature) (Date)

This credit is subject to the most recent edition of the Uniform Customs and Practice for Documentary Credits, International Chamber of Commerce Publication No. 600, and any subsequent revisions thereof approved by a congress of the International Chamber of Commerce and adhered to by us. If this credit expires during an interruption of business as described in Article 36 of said Publication 600, the bank hereby specifically agrees to effect payment if this credit is drawn against within thirty (30) days after resumption of our business.

E. Assignment of certificate of deposit account.

City _____ _____, 20___

FOR VALUE RECEIVED, the undersigned assigns all right, title and interest to the Virginia Department of Environmental Quality, Commonwealth of Virginia, and its successors and assigns the Virginia Department of Environmental Quality the principal amount of the instrument, including all moneys deposited now or in the future to that instrument, indicated below:

This assignment includes all interest now and hereafter accrued.

Certificate of Deposit Account No. _____

This assignment is given as security to the Virginia Department of Environmental Quality in the amount of _____ Dollars ($_____).

Continuing Assignment. This assignment shall continue to remain in effect for all subsequent terms of the automatically renewable certificate of deposit.

Assignment of Document. The undersigned also assigns any certificate or other document evidencing ownership to the Virginia Department of Environmental Quality.

Additional Security. This assignment shall secure the payment of any financial obligation of the (name of owner) to the Virginia Department of Environmental Quality for operation and maintenance and/or replacement at the (entity name) located (physical address).

Application of Funds. The undersigned agrees that all or any part of the funds of the indicated account or instrument may be applied to the payment of any and all financial assurance obligations of (name of owner) to the Virginia Department of Environmental Quality for operation and maintenance and/or replacement at the (entity name and address). The undersigned authorizes the Virginia Department of Environmental Quality to withdraw any principal amount on deposit in the indicated account or instrument including any interest, if indicated, and to apply it in the Virginia Department of Environmental Quality's discretion to fund (operation and maintenance and/or replacement) at the (entity name) or in the event of (owner) failure to comply with the 9VAC25-900. The undersigned agrees that the Virginia Department of Environmental Quality may withdraw any principal and/or interest from the indicated account or instrument without demand or notice. (The undersigned) agrees to assume any and all loss of penalty due to federal regulations concerning the early withdrawal of funds. Any partial withdrawal of principal or interest shall not release this assignment.

The party or parties to this Assignment set their hand or seals, or if corporate, has caused this assignment to be signed in its corporate name by its duly authorized officers and its seal to be affixed by authority of its Board of Directors the day and year above written.

SEAL

(Owner)

(print owner's name)

SEAL

(Owner)

(print owner's name)

THE FOLLOWING SECTION IS TO BE COMPLETED BY THE BRANCH OR LENDING OFFICE:

The signature(s) as shown above compare correctly with the name(s) as shown on record as owner(s) of the Certificate of Deposit indicated above. The above assignment has been properly recorded by placing a hold in the amount of $ _____ for the benefit of the Department of Environmental Quality.

The accrued interest on the Certificate of Deposit indicated above shall be maintained to capitalize versus being mailed by check or transferred to a deposit account.

(Signature) (Date)

(print name)

(Title)

F. Wording of insurance endorsement.

ENDORSEMENT.

[NOTE: The instructions in brackets are to be replaced by the relevant information and the brackets deleted.]

Name: [name of each covered location]

Address: [address of each covered location]

Policy number:

Period of coverage: [current policy period]

Name of Insurer:

Address of Insurer:

Name of insured:

Address of insured:

Endorsement:

1. This endorsement certifies that the policy to which the endorsement is attached provides insurance covering the operation and maintenance and/or replacement in connection with the insured's obligation to demonstrate financial responsibility under the 9VAC25-900).

[List the name(s) and address(es) of the nutrient credit-generating entity(ies)]

for [insert: "operating and maintaining and/or replacement of the nutrient credit-generating entity] in accordance with and subject to the limits of liability, exclusions, conditions, and other terms of the policy;

The limits of liability are [insert the dollar amount of the operation and maintenance and/or replacement], exclusive of legal defense costs, which, if applicable, are subject to a separate limit under the policy. This coverage is provided under [policy number]. The effective date of said policy is [date].

2. The insurance afforded with respect to such occurrences is subject to all of the terms and conditions of the policy; provided, however, that any provisions inconsistent with subsections (a) through (d) for occurrence policies and (a) through (e) for claims-made policies of this paragraph 2 are hereby amended to conform with subsections (a) through (e):

a. Bankruptcy or insolvency of the insured shall not relieve the insurer of its obligations under the policy to which this endorsement is attached.

b. The insurer is liable for the payment of amounts within any deductible applicable to the policy to the provider of operation and maintenance and/or replacement, with a right of reimbursement by the insured for any such payment made by the insurer. This provision does not apply with respect to that amount of any deductible for which coverage is demonstrated under another mechanism or combination of mechanisms as specified in 9VAC25-900.

c. Whenever requested by the State Water Control Board, the insurer agrees to furnish to State Water Control Board a signed duplicate original of the policy and all endorsements.

d. The insurer may not fail to renew the policy except for failure to pay the premium. The automatic renewal of the policy shall, at a minimum, provide the insured with the option of renewal at the face amount of the expiring policy.

e. The insured may cancel the insurance policy only if alternate financial assurance is substituted as specified in 9VAC25-900, or if the owner is no longer required to demonstrate financial responsibility in accordance with 9VAC25-900.

f. Cancellation for nonpayment of premium or misrepresentation by the insured will be effective only upon written notice and only after expiration of a minimum of 120 days after a copy of such written notice is received by the insured and the State Water Control Board.

[Insert for claims-made policies:]

g. The insurance covers claims otherwise covered by the policy that are reported to the insurer within six months of the effective date of cancellation or nonrenewal of the policy except where the new or renewed policy has the same retroactive date or a retroactive date earlier than that of the prior policy, and which arise out of any covered occurrence that commenced after the policy

retroactive date, if applicable, and prior to such policy renewal or termination date. Claims reported during such extended reporting period are subject to the terms, conditions, limits, including limits of liability, and exclusions of the policy.

I hereby certify that the wording of this endorsement is in no respect less favorable than the coverage specified in 9VAC25-900. I further certify that the insurer is licensed to transact the business of insurance or eligible to provide insurance as an excess or surplus lines insurer in the Commonwealth of Virginia.

[Signature of authorized representative of insurer]

[Name of person signing]

[Title of person signing], authorized representative of [name of insurer]

[Address of representative]

(Title of person signing)

Signature of witness or notary:

(Date)

DOCUMENTS INCORPORATED BY REFERENCE (9VAC25-900)

DCR Specifications for No. FR-3, Woodland Buffer Filter Area, Virginia Agricultural Cost Share BMP Manual, Program Year 2014, July 2013, Department of Conservation and Recreation

DCR Specifications for No. SL-8B, Small Grain Cover Crop for Nutrient Management and Residue Management, Virginia Agricultural Cost Share BMP Manual, Program Year 2014, July 2013, Department of Conservation and Recreation

DCR Specifications for No. WP-2, Stream Protection, Virginia Agricultural Cost Share BMP Manual, Program Year 2014, July 2013, Department of Conservation and Recreation

DCR Specifications for No. WQ-1, Grass Filter Strips, Virginia Agricultural Cost Share BMP Manual, Program Year 2014, July 2013, Department of Conservation and Recreation

VA.R. Doc. No. R13-3379; Filed December 1, 2014, 2:20 p.m.

◆ ◆

TITLE 12. HEALTH

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Final Regulation

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

12VAC30-60. Standards Established and Methods Used to Assure High Quality Care (amending 12VAC30-60-61, 12VAC30-60-143; adding 12VAC30-60-5).

12VAC30-130. Amount, Duration and Scope of Selected Services (adding 12VAC30-130-2000, 12VAC30-130-3000, 12VAC30-130-3010, 12VAC30-130-3020, 12VAC30-130-3030).

Statutory Authority: §§ 32.1-324 and 32.1-325 of the Code of Virginia; 42 USC § 1396 et seq.

Effective Date: January 30, 2015.

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Summary:

The amendments comply with items in the budget bill that require changes in the provisions of intensive in-home services and community mental health support services to ensure appropriate utilization, cost efficiency, and provider qualifications appropriate to render these services. This action includes: (i) changes to provider qualifications including meeting licensing standards; (ii) marketing requirements and restrictions; (iii) new assessment requirements; and (iv) language enhancements for utilization review requirements to help providers avoid payment retractions. New independent clinical assessments, conducted by local community services boards or behavioral health authorities, are required prior to the onset of specified services until the department's behavioral health services administrator contractor can assume this responsibility. Providers that are permitted to claim Medicaid reimbursement for specific services are specified by license type.

Changes made since publication of the proposed regulation include: (i) terminology changes; (ii) permitting additional provider types to render services (e.g., in addition to Licensed Mental Health Professionals (LMHPs), LMHP-supervisees, LMHP-residents, and LMHP-residents in psychology are added); (iii) adding full-time equivalency of part-time work experience; (iv) providing for different professional employees of the same provider to use electronic health records; (v) providing that the provider secure written permission from the individual before communicating with the individual's primary care provider concerning the receipt of community mental health services; (vi) correctly identifying the Department of Behavioral Health and Developmental Services licenses that certain providers are required to secure prior to becoming a Medicaid provider and rendering services; and (vii) removing the limitation of intensive community treatment services to adults in response to a directive from the Centers for Medicare and Medicaid Services.

Summary of Public Comments and Agency's Response: A summary of comments made by the public and the agency's

response may be obtained from the promulgating agency or viewed at the office of the Registrar of Regulations.

12VAC30-50-130. Skilled nursing facility services, EPSDT, school health services, and family planning.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Human services field" means [~~, for the purpose of (i) intensive in-home, (ii) day treatment for children and adolescents, (iii) community-based residential services for children and adolescents younger than 21 (Level A), and (iv) therapeutic behavioral services (Level B), social work, psychology, sociology, counseling, special education, human child or family development, cognitive or behavioral sciences, marriage and family therapy, or art or music therapy~~ the same as the term is defined by DBHDS in the document entitled Human Services and Related Fields Approved Degrees/Experience, issued March 12, 2013, revised May 3, 2013].

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

"Licensed mental health professional" or "LMHP" means [~~the same as the term defined in 12VAC35-105-20~~ a licensed physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, or certified psychiatric clinical nurse specialist.

"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.]

"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, [~~as~~ at] a minimum, the name of the service rendered, the date of the service rendered, the signature and credentials of the person who rendered the service, the setting in which the service was rendered, and the amount of time or units/hours required to deliver the service. The content of each progress note shall corroborate the time/units billed. Progress notes shall be documented for each service that is billed.

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

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

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

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

"Qualified paraprofessional in mental health" or "QPPMH" means the same as the term is defined in

12VAC35-105-20 [and consistent with the requirements of 12VAC35-105-1370].

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

~~a.~~ b. Intensive in-home services [(IIH)] to children and adolescents under age 21 shall be time-limited interventions provided [~~typically but not solely in the residence~~ in the individual's residence and when clinically necessary in community settings. All interventions and the settings of the intervention shall be defined in the Individual Service Plan. All IIH services shall be designed to specifically improve family dynamics, provide modeling, and the clinically necessary interventions that increase functional and therapeutic interpersonal relations between family members in the home. IIH services are designed to promote psychoeducational benefits in the home setting] of ~~a child~~ 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 ~~child~~ individual. These services provide crisis treatment; individual and family counseling; ~~and~~ communication skills (e.g., counseling to assist the ~~child~~ individual and his parents or guardians, as appropriate, to understand and practice appropriate problem solving, anger management, and interpersonal interaction, etc.); ~~case management activities and~~ care coordination with other required services; and 24-hour emergency response.

(1) These services shall be limited annually to 26 weeks. ~~After an initial period, prior authorization is required for Medicaid reimbursement.~~ Service authorization shall be required for Medicaid reimbursement prior to the onset of services. Services rendered before the date of authorization shall not be reimbursed.

(2) Service authorization shall be required for services to continue beyond the initial 26 weeks.

(3) Service-specific provider [~~assessments~~ 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 [~~assessments~~ intakes] or ISPs shall be denied reimbursement. Requirements for service-specific provider [~~assessments~~ intakes] and ISPs are set out in [~~12VAC30-50-130~~ this section] .

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

~~b.~~ c. Therapeutic day treatment [(TDT)] shall be provided two or more hours per day in order to provide therapeutic interventions. Day treatment programs, limited annually to 780 units, 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 [~~psychotherapy~~ counseling].

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

(2) Service-specific provider [~~assessments~~ 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 [~~assessments~~ intakes] or ISPs shall be denied reimbursement. Requirements for service-specific provider [~~assessments~~ intakes] and ISPs are set out in [~~12VAC30-50-130~~ this section].

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

~~c.~~ d. Community-based services for children and adolescents under 21 [years of age] (Level A).

(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. ~~DMAS will reimburse only for services provided in facilities or programs with no more than 16 beds.~~ 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 ~~a licensed mental health professional~~ an LMHP [, LMHP-supervisee, LMHP-resident, or LMHP-RP].

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

(4) Authorization ~~is~~ 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 ~~are~~ shall not be reimbursed. ~~Facilities that only provide independent living services are not reimbursed.~~ DMAS shall reimburse only for services provided in facilities or programs with no more than 16 beds.

(6) ~~Providers~~ These residential providers must be licensed by the Department of Social Services, Department of Juvenile Justice, or ~~Department of Education~~ Department of Behavioral Health [and] Developmental Services under the Standards for ~~Interdepartmental Regulation of~~ Licensed Children's Residential Facilities (22VAC40-151), Standards for Interim Regulation of Children's Residential Facilities (6VAC35-51), or Regulations for Children's Residential Facilities ~~(22VAC42-10)~~ (12VAC35-46).

(7) Daily progress notes shall document a minimum of seven psychoeducational activities per week. Psychoeducational programming must include, but is not limited to, development or maintenance of daily living skills, anger management, social skills, family living skills, communication skills, [~~and~~] 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 [~~assessments~~ 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 [~~assessments~~ intakes] or ISPs shall be denied reimbursement. Requirements for [~~assessments~~ 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.~~ e. Therapeutic behavioral services (Level B).

(1) Such services must be therapeutic services rendered in a residential setting that provides 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. ~~DMAS will reimburse only for services provided in facilities or programs with no more than 16 beds.~~ The application of a national standardized set of medical necessity criteria in use in the industry, such as McKesson InterQual® Criteria, or an equivalent standard authorized in advance by DMAS shall be required for this service.

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

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

(4) ~~Providers~~ These residential providers must be licensed by the Department of ~~Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS)~~ Behavioral Health and Developmental Services (DBHDS) under the ~~Standards~~ Regulations for ~~Interdepartmental Regulation of~~ Children's Residential Facilities ~~(22VAC42-10)~~ (12VAC35-46).

(5) Daily progress notes shall document that a minimum of seven psychoeducational activities per week occurs. Psychoeducational programming must include, but is not limited to, 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 ~~child~~ individual must receive, at least weekly, individual psychotherapy and, at least weekly, group psychotherapy that is provided as part of the program.

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

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

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

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

6. Inpatient psychiatric services shall be covered for individuals younger than age 21 for medically necessary stays for the purpose of diagnosis and treatment of mental health and behavioral disorders identified under EPSDT when such services are rendered by:

a. A psychiatric hospital or an inpatient psychiatric program in a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations; or a psychiatric facility that 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 the Council on Quality and Leadership.

b. 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 [~~this chapter~~ Amount, Duration and Scope of Selected Services].

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

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

C. School health services.

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

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

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

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

3. Service 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. Service providers shall be employed by the school division or under contract to the school division.

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

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

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

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

4. Covered services include:

a. Physical therapy, occupational therapy and services for individuals with speech, hearing, and language disorders,

performed by, or under the direction of, providers who meet the qualifications set forth at 42 CFR 440.110. This coverage includes audiology services~~;~~.

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

(1) The coverage of skilled nursing services shall be of a level of complexity and sophistication (based on assessment, planning, implementation and evaluation) that is consistent with skilled nursing services when performed by a licensed registered nurse or a licensed practical nurse. These skilled nursing services shall include, but not necessarily be limited to dressing changes, maintaining patent airways, medication administration/monitoring and urinary catheterizations.

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

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

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

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

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

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

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

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

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

2. Family planning services shall be defined as those services that delay or prevent pregnancy. Coverage of such services shall not include services to treat infertility nor services to promote fertility.

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

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:

"Certified prescreener" means an employee of either the local ~~community services board~~ community services board/behavioral health authority [~~, behavioral health service administrator~~] 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 support, (v) crisis stabilization, and (vi) crisis intervention services,~~] practical experience in providing direct services on a full-time basis [(or the equivalent part-time experience as determined by DBHDS in the document entitled Human Services and Related Fields Approved Degrees/Experience, issued March 12, 2013, revised May 3, 2013)] to individuals with medically-documented diagnoses of mental illness or ~~mental retardation~~ intellectual/developmental disability or the provision of direct geriatric services or full-time [(or the equivalent part-time experience)] special education services [, for the purpose of rendering (i) mental health day treatment/partial hospitalization, (ii) intensive community treatment, (iii) psychosocial rehabilitation, (iv) mental health support, (v) crisis stabilization, or (vi) crisis intervention services]. Experience ~~may~~ shall include supervised internships, supervised practicums, ~~and~~ or supervised field experience. Experience shall not include unsupervised internships, unsupervised practicums, and unsupervised field experience. This required clinical experience shall be calculated as set forth in [~~12VAC35-105-20~~ DBHDS document entitled 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.

"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.

"Human services field" means [~~for the purpose of (i) mental health day treatment/partial hospitalization, (ii) intensive community treatment, (iii) psychosocial rehabilitation, (iv) mental health support, (v) crisis stabilization, and (vi) crisis intervention services, social work, gerontology, psychology, psychiatric rehabilitation, special education, sociology, counseling, vocational rehabilitation, behavioral sciences, marriage and family therapy, art or music therapy, and human services counseling~~] ~~or other degrees deemed equivalent by DMAS~~ [the same as defined by DBHDS in the document entitled Human Services and Related Fields Approved Degrees/Experience, issued March 12, 2013, revised May 3, 2013].

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

"Individual service plan" or "ISP" means a comprehensive and regularly updated ~~statement~~ treatment plan specific to the ~~individual being treated containing, but not necessarily limited to, his treatment or training needs, his goals and measurable objectives to meet the identified needs, services to be provided with the recommended frequency to accomplish the measurable goals and objectives, and estimated timetable for achieving the goals and objectives. The provider shall include the individual in the development of the ISP. To the extent that the individual's condition requires assistance for participation, assistance shall be provided. The ISP shall be updated as the needs and progress of the individual changes.~~ individual's unique treatment needs as identified in the clinical assessment. The ISP contains his treatment or training needs, his goals and measurable objectives to meet the identified needs, services to be provided with the recommended frequency to accomplish the measurable goals and objectives, the estimated timetable for achieving the goals and objectives, and an individualized discharge plan that describes transition to other appropriate services. The [individual shall be included in the development of the ISP and the] ISP shall be signed by the individual. If the individual is a [~~minor~~] child, the ISP shall also be signed by the individual's parent/legal guardian. Documentation shall be provided if the individual, who is a [~~minor~~] child [or an adult who lacks legal capacity], is unable or unwilling to sign the ISP.

"Licensed [~~Mental Health Professional"~~ mental health professional"] or "LMHP" means ~~an individual licensed in Virginia as a physician, a clinical psychologist, a professional counselor, a clinical social worker, or a psychiatric clinical nurse specialist~~ [~~the same as defined in 12VAC30-105-20~~ a licensed physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, or certified psychiatric clinical nurse specialist].

["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.]

~~"Qualified mental health professional" or "QMHP" means a clinician in the human services field who is trained and experienced in providing psychiatric or mental health services to individuals who have a psychiatric diagnosis. If the QMHP is also one of the defined licensed mental health professionals, the QMHP may perform the services designated for the Licensed Mental Health Professionals unless it is specifically prohibited by their licenses. These QMHPs may be either a:~~

~~1. Physician who is a doctor of medicine or osteopathy and is licensed in Virginia;~~

~~2. Psychiatrist who is a doctor of medicine or osteopathy, specializing in psychiatry and is licensed in Virginia;~~

~~3. Psychologist who has a master's degree in psychology from an accredited college or university with at least one year of clinical experience;~~

~~4. Social worker who has a master's or bachelor's degree from a school of social work accredited or approved by the Council on Social Work Education and has at least one year of clinical experience;~~

~~5. Registered nurse who is licensed as a registered nurse in the Commonwealth and has at least one year of clinical experience; or~~

~~6. Mental health worker who has at least:~~

~~a. A bachelor's degree in human services or a related field from an accredited college and who has at least one year of clinical experience;~~

~~b. Registered Psychiatric Rehabilitation Provider (RPRP) registered with the International Association of Psychosocial Rehabilitation Services (IAPSRS) as of January 1, 2001;~~

~~c. A bachelor's degree from an accredited college in an unrelated field with an associate's degree in a human services field. The individual must also have three years clinical experience;~~

~~d. A bachelor's degree from an accredited college and certification by the International Association of Psychosocial Rehabilitation Services (IAPSRS) as a Certified Psychiatric Rehabilitation Practitioner (CPRP);~~

~~e. A bachelor's degree from an accredited college in an unrelated field that includes at least 15 semester credits (or equivalent) in a human services field. The individual must also have three years clinical experience; or~~

~~f. Four years clinical experience.~~

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

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

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

"Qualified paraprofessional in mental health" or "QPPMH" means ~~an individual who meets at least one of the following criteria:~~ the same as defined in 12VAC35-105-20.

~~1. Registered with the International Association of Psychosocial Rehabilitation Services (IAPSRS) as an Associate Psychiatric Rehabilitation Provider (APRP), as of January 1, 2001;~~

~~2. Has an associate's degree in one of the following related fields (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services counseling) and has at least one year of experience providing direct services to persons with a diagnosis of mental illness;~~

~~3. An associate's or higher degree, in an unrelated field and at least three years experience providing direct services to persons with a diagnosis of mental illness, gerontology clients, or special education clients. The experience may include supervised internships, practicums and field experience.~~

~~4. A minimum of 90 hours classroom training in behavioral health and 12 weeks of experience under the direct personal supervision of a QMHP providing services to persons with mental illness and at least one year of clinical experience (including the 12 weeks of supervised experience).~~

~~5. College credits (from an accredited college) earned toward a bachelor's degree in a human service field that is equivalent to an associate's degree and one year's clinical experience.~~

~~6. Licensure by the Commonwealth as a practical nurse with at least one year of clinical experience.~~

"Register" or "registration" means notifying DMAS or its contractor that an individual will be receiving [~~either crisis stabilization or~~ ~~crisis intervention~~ services that do not require service authorization].

"Service authorization" means the [~~final determination of Medicaid reimbursement made by either DMAS or its , service authorization contractor for specified medical services for a specified individual to be rendered by a specified provider.~~ 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.]

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 supports. Staff travel time shall not be included in billable time for reimbursement.

[1. 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.

2. These services are intended to be delivered in a person-centered manner. The individuals who are receiving these services shall be included in all service planning activities. All services which do not require service authorization require registration. This registration shall transmit to DMAS or its contractor (i) the individual's name and Medicaid identification number; (ii) the specific service to be provided, the relevant procedure code and begin date of the service; and (iii) the provider's name and NPI, a provider contact name and phone number, and email address.

~~1.~~ 3.] 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 [~~assessment~~ 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 ~~requires~~ 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 either an LMHP, [LMHP-supervisee, LMHP-resident, LMHP-RP,] QMHP-A, QMHP-C, [QMHP-E,] or a QPPMH.

[~~2.~~ 4.] Psychosocial rehabilitation shall be provided at least two or more hours per day to groups of individuals in a nonresidential setting. These services, limited annually to 936 units, include assessment, education to teach the patient about the diagnosed mental illness and appropriate medications to avoid complication and relapse, opportunities to learn and use independent living skills and to enhance social and interpersonal skills within a supportive and normalizing program structure and environment. One unit of service is defined as a minimum of two but less than four hours on a given day. Two units are defined as at least four but less than seven hours in a given day. Three units of service shall be defined as seven or more hours in a given day. Authorization is required for Medicaid reimbursement. The service-specific provider [~~assessment~~ 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:

~~a.~~ (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;

~~b.~~ (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;

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

~~d.~~ (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 either an LMHP [LMHP-supervisee, LMHP-resident, LMHP-RP,] QMHP-A, QMHP-C, [QMHP-E,] or a QPPMH.

[~~3.~~ 5.] 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 [~~assessment~~ 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 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. [~~This registration shall transmit to DMAS or its contractor: (i) the individual's name and Medicaid identification number; (ii) the specific service to be provided, the relevant procedure code, begin date of the service, and the amount of the service that will be provided; and (iii) the provider's name and NPI, a provider contact name and phone number, and email address.~~]

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, [~~QMHP-A, or QMHP-C and~~ an LMHP-supervisee, LMHP-resident, LMHP-RP, or] a certified [~~pre-screener~~ prescreener].

[~~4.~~ 6.] Intensive community treatment (ICT), initially covered for a maximum of 26 weeks based on an initial service-specific provider [~~assessment with continuation~~ intake and may be] reauthorized for [up to] an additional 26 weeks annually based on written [~~assessment~~ intake] and certification of need by a [~~qualified~~ licensed] mental

health provider [~~(QMHP)~~ (LMHP)], shall be defined [~~as~~ by 12VAC35-105-20 or LMHP-S, LMHP-R, and LMHP-RP and shall include] medical psychotherapy, psychiatric assessment, medication management, and ~~case management~~ care coordination activities offered to outpatients outside the clinic, hospital, or office setting for individuals who are best served in the community. ~~The annual unit limit shall be 130 units with a unit equaling one hour.~~ Authorization is required for Medicaid reimbursement.

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

~~a.~~ (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.

~~b.~~ (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.

~~(1) An~~ b. A written, service-specific provider [~~assessment~~ 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 [~~assessment~~ intake] must be maintained in the individual's records.

~~(2) A service plan must~~ c. An individual service plan shall be initiated at the time of admission and must be fully developed, as defined in [~~12VAC30-50-226~~ 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 [~~an LMHP, QMHP-A, QMHP-C, and QPPMH~~ a team that meets the requirements of 12VAC35-105-1370].

[~~5.~~ 7.] 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. ~~Authorization~~ Services may be authorized for up to a 15-day period per crisis episode following a ~~documented~~ face-to-face service-specific provider [~~assessment~~ intake] by [~~a~~] ~~QMHP which~~ [~~QMHP-A or QMHP-C that is reviewed and approved by~~] an LMHP [~~within 72 hours of the assessment~~ , LMHP-supervisee, LMHP-resident, or LMHP-RP]. ~~The maximum limit on this service is up to eight hours (with a unit being one hour) per day up to 60 days annually.~~ Only one unit of service shall be reimbursed for this [~~assessment~~ intake]. The provision of this service to an individual shall be registered with either DMAS or the BHSA [within one calendar day of the completion of the service-specific provider intake] to avoid duplication of services and to ensure informed care coordination. [~~This registration shall transmit to DMAS or its contractor: (i) the individual's name and Medicaid identification number; (ii) the specific service to be provided, the relevant procedure code, begin date of the service, and the amount of the service that will be provided; and (iii) the provider's name and NPI, a provider contact name and phone number, and email address. (~~See 12VAC30-50-226 B for registration requirements.]

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 ~~recipients~~ 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 ~~a recipient~~ an individual who lives with family or other primary caregiver; (ii) the home of ~~a recipient~~ 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) ~~recipients~~ individuals with medical conditions that require hospital care; (ii) ~~recipients~~ individuals with primary diagnosis of substance abuse; or (iii) ~~recipients~~ individuals with psychiatric conditions that cannot be managed in the community (i.e., ~~recipients~~ 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 [~~assessment~~ 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:

~~a.~~ (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;

~~b.~~ (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;

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

~~d.~~ (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, [~~or~~] QMHP-C [~~and~~, QMHP-E, or] a certified [~~pre-screener~~ prescreener].

[~~6.~~ 8.] Mental health support services (MHSS) shall be defined as training and supports 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 ~~for~~ up to six consecutive months as long as the individual meets the coverage criteria for this service. The service-specific provider [~~assessment~~ intake], as defined at 12VAC30-50-130, shall document the individual's behavior and describe how the individual meets criteria for this service. This program shall provide the following services in order to be reimbursed by Medicaid: training in or reinforcement of functional skills and appropriate behavior related to the individual's health and safety, activities of daily living, and use of community resources; assistance with medication management; and monitoring health, nutrition, and physical condition.

a. Individuals qualifying for this service must 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 without these services would be unable to remain in the community. The individual must ~~have~~ meet at least two of the following criteria on a continuing or intermittent basis:

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

(2) Require help in basic living skills 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 recognize significantly inappropriate social behavior.

b. The individual must demonstrate functional impairments in major life activities. This may include individuals with a dual diagnosis of either mental illness and [~~mental retardation~~ intellectual disability], or mental illness and substance abuse disorder.

c. Service-specific provider [~~assessments~~ 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 [~~assessments~~ intakes] or ISPs shall be denied reimbursement. Requirements for provider-specific [~~assessments~~ intakes] and ISPs are set out in 12VAC30-50-130.

~~e.~~ d. The yearly limit for mental health support services is 372 units. One unit is [at least] one hour but less than three hours.

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

[DOCUMENTS INCORPORATED BY REFERENCE (12VAC30-50)

Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition DSM-IV-TR, copyright 2000, 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 2005 (www.dmas.virginia.gov/downloads/pdfs/dental-office_reference_manual_0 6-09-05.pdf).

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

Virginia Medicaid Durable Medical Equipment and Supplies Provider Manual, Appendix B (rev. 1/11), Department of Medical Assistance Services.

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

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 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' care. Such documentation shall fully disclose the extent of services provided in order to support providers' 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, shall perform reviews of the utilization of all Medicaid covered services pursuant to [42 CFR] 440.260 and [~~456.1 et seq.~~ 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, 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] to be reimbursed. Once a health care entity has been enrolled as a provider, it shall maintain, and update periodically as DMAS 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 [~~who~~ that] either hold provisional licenses or [~~who~~] fail to enter into a Medicaid Provider Enrollment Agreement for a service prior to rendering that service.

[4. The behavioral health service authorization 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.]

12VAC30-60-61. Services related to the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT); community mental health 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 [~~after completion of~~ before] the [~~assessment~~ 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 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 [~~or~~ nor] consultant to the [~~IIH~~ 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 days; (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 residential treatment facility Level C services, (b) transitioning out of a 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 service or 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 [~~is understood to mean~~ includes] children [from birth up to 12 years of age] or adolescents [ages 12 through 20 years].

"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 group home; (ii) regular foster home if the individual is currently residing with his 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 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 residential 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.

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

B. [~~These~~ 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.

~~A.~~ C. 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.

~~1.~~ 2. Individuals qualifying for this service ~~must~~ shall demonstrate a clinical necessity for the service arising from mental, behavioral or emotional illness which 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.

~~2. At~~ 3. Prior to admission, an appropriate service-specific provider [~~assessment~~ intake] ~~is made~~, as defined in 12VAC30-50-130, shall be conducted by the ~~LMHP or the QMHP and approved by the LMHP,~~ licensed mental health professional (LMHP), [~~as defined in 12VAC35-105-20,~~ LMHP-supervisee, LMHP-resident, or LMHP-RP,] documenting ~~that~~ the individual's diagnosis and describing how service needs can best be met through intervention provided typically but not solely in the ~~client's~~ individual's residence. ~~An Individual Service Plan (ISP) must be fully completed within 30 days of initiation of services.~~ The service-specific provider [~~assessment~~ 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 [~~assessments~~ 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, [~~as defined in 12VAC35-105-20,~~ or a QMHP-E] and the individual and individual's parent/guardian within 30 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.

~~3.~~ 6. Services ~~must~~ shall be directed toward the treatment of the eligible ~~child~~ individual and delivered primarily in the family's residence with the ~~child~~ individual present. ~~In some circumstances, such as lack of privacy or unsafe conditions, services may be provided in the community if supported by the needs assessment and ISP.~~ [~~The assessment may be performed and~~ 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.

~~4.~~ 7. These services shall be provided when the clinical needs of the ~~child~~ individual put ~~the child~~ him 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 ~~child~~ individual in the family situation, or

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

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

~~5. Services may not be billed when provided to a family while the child is not residing in the home.~~

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

~~6.~~ 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 ~~child~~ individual and responsible parent/guardian ~~must~~ shall be available and in agreement to participate in the transition.

~~7.~~ 10. At least one ~~parent~~ [~~parent/guardian~~ parent/legal guardian] or responsible adult with whom the ~~child~~ individual is living must be willing to participate in the intensive in-home services with the goal of keeping the ~~child~~ 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.]

~~8.~~ 11. The enrolled [service] provider ~~must~~ shall be licensed by the Department of ~~Mental Health, Mental Retardation and Substance Abuse Services~~ 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.

~~9.~~ 12. Services must only be provided by an LMHP [, LMHP-supervisee, LMHP-resident, LMHP-RP,] ~~or a, QMHP~~ [~~or~~] QMHP-C [~~as defined in~~, or QMHP-E] ~~12VAC30-50-226~~ [~~12VAC35-105-20~~]. Reimbursement shall not be provided for such services when they have been rendered by a QPPMH as defined in ~~12VAC30-50-226~~ 12VAC35-105-20.

~~10.~~ 13. The billing unit for intensive in-home service ~~is~~ 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 [~~a~~] ~~plan of care~~ [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 ~~client/family~~ individual/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 ~~client~~ individual and family initially with a lessening or tapering off of intensity toward the latter weeks of service. Service plans ~~must~~ shall incorporate ~~a~~ an individualized discharge plan ~~which identifies~~ 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 guardian or the individual with the service provider], the provider shall discharge the individual. If the individual continues to need services, then a new [~~assessment/admission~~ intake/admission] shall be documented and a new service authorization shall be required.

~~11.~~ 15. The provider ~~must~~ shall ensure that the maximum staff-to-caseload ratio fully meets the needs of the individual.

~~12. Since case management services are an integral and inseparable part of this service, case management services may not be billed separately for periods of time when intensive in-home services are being provided.~~

16. If an individual receiving services is also receiving case management services pursuant to 12VAC30-50-420 or 12VAC30-50-430, the [service] 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 days of the service discontinuation date. [Service 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.]

~~13.~~ 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 of the individual's receipt of IIH services. The documentation shall include who was contacted, when the contact occurred, and what information was transmitted.

~~B.~~ D. 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.

~~1.~~ 2. Therapeutic day treatment is appropriate for children and adolescents who meet one of the following:

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; (iv) are extremely depressed or marginally connected with reality.

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

3. The service-specific provider [~~assessment~~ 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 [~~assessment~~ 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, [~~as defined in 12VAC35-105-20,~~ or QMHP-E] and by the individual or the parent/guardian within 30 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.

~~2.~~ 6. Such services ~~must~~ shall not duplicate those services provided by the school.

~~3.~~ 7. Individuals qualifying for this service ~~must~~ shall demonstrate a clinical necessity for the service arising from a condition due to mental, behavioral or emotional illness which results in significant functional impairments in major life activities. Individuals ~~must~~ 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.

~~4.~~ 8. The enrolled provider of therapeutic day treatment for child and ~~adolescents~~ adolescent services ~~must~~ shall be licensed by ~~the Department of Mental Health, Mental Retardation and Substance Abuse Services~~ 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.

~~5.~~ 9. Services ~~must~~ shall be provided by an LMHP [, LMHP-supervisee, LMHP-resident, LMHP-RP,] ~~, a QMHP, or a QPPMH who is supervised by a QMHP or LMHP~~ [~~or~~] QMHP-C [~~as defined in 12VAC35-105-20,~~ or QMHP-E].

~~6.~~ 10. The minimum ~~staff-to-youth~~ staff-to-individual ratio as defined by DBHDS licensing requirements shall ensure that adequate staff is available to meet the needs of the ~~youth~~ individual identified on the ISP.

~~7.~~ 11. The program ~~must~~ 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 ~~is~~ 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.

~~8.~~ 12. Time required for academic instruction when no treatment activity is going on ~~cannot~~ shall not be included in the billing unit.

~~9.~~ 13. Services shall be provided following a ~~diagnostic~~ service-specific provider [~~assessment~~ intake] that is ~~authorized~~ conducted by an LMHP [~~as defined in 12VAC35-105-20~~, LMHP-supervisee, LMHP-resident, or LMHP-RP]. ~~Services must be provided in accordance with an ISP which must be fully completed within 30 days of initiation of the service.~~ An LMHP [, LMHP-supervisee, or LMHP-resident] shall make and document the diagnosis. The service-specific provider [~~assessment~~ intake] shall include the elements [~~specified in subsection A of this section~~ 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 days of the service discontinuation date. [Service 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 guardian, shall] inform him of the child'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 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 [~~assessment/admission~~ intake/admission] documentation shall be prepared and a new service authorization shall be required.

~~C.~~ E. [~~Community-Based Services for Children and Adolescents~~ Community-based services for children and adolescents] under 21 [years of age] (Level A)

1. The staff ratio must be at least 1 to 6 during the day and at least 1 to 10 ~~while asleep~~ between 11 p.m. and 7 a.m. The program director supervising the program/group home must be, at minimum, a ~~qualified mental health professional~~ QMHP-C [~~,~~ or QMPH-E] (as defined in 12VAC35-105-20) ~~with a bachelor's degree and have at least one year of direct work with mental health clients~~. The program director must be employed full time.

2. ~~At~~ In order for Medicaid reimbursement to be approved, at least 50% of the provider's direct care staff at the group home must meet ~~DMAS~~ DBHDS paraprofessional staff criteria, defined in ~~12VAC30-50-226~~ 12VAC35-105-20.

3. Authorization is required for Medicaid reimbursement. ~~DMAS shall monitor the services rendered. All Community-Based Services for Children and Adolescents under 21 (Level A) must be authorized prior to reimbursement for these services. Services rendered without such authorization shall not be covered.~~ All community-based services for children and adolescents under 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~~ individual service plan] (ISP) ~~(plan of care)~~, which must be fully completed within 30 days of authorization for Medicaid reimbursement.

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

6. Such service-specific provider [~~assessments~~ intakes] shall be performed by an LMHP [~~as defined in 12VAC35-105-20~~, an LMHP-supervisee, LMHP-resident, or LMHP-RP].

7. If an individual receiving community-based services for children and adolescents under 21 (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. [Service 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.]

~~D.~~ F. Therapeutic [~~Behavioral Services for Children and Adolescents~~ behavioral services for children and adolescents] under 21 [years of age] (Level B).

1. The staff ratio must be at least 1 to 4 during the day and at least 1 to 8 ~~while asleep~~ between 11 p.m. and 7 a.m. The clinical director must be a licensed mental health professional. The caseload of the clinical director must not exceed 16 ~~clients~~ individuals including all sites for which the [same] clinical director is responsible. ~~The program director must be full time and be a qualified mental health professional with a bachelor's degree and at least one year's clinical experience.~~

2. The program director must be full time and be a [~~qualified mental health professional~~ QMHP-C or QMHP-E] with a bachelor's degree and at least one year's clinical experience.

~~2. At~~ 3. For Medicaid reimbursement to be approved, at least 50% of the provider's direct care staff ~~must~~ at the group home shall meet [~~DMAS~~ DBHDS] paraprofessional staff criteria, as defined in ~~12VAC30-50-226~~ 12VAC35-105-20. The program/group home must coordinate services with other providers.

~~3.~~ 4. All [~~Therapeutic Behavioral Services~~ therapeutic behavioral services] (Level B) ~~must~~ shall be authorized prior to reimbursement for these services. Services rendered without such prior authorization shall not be covered.

~~4.~~ 5. Services must be provided in accordance with an ISP ~~(plan of care)~~, which ~~must~~ shall be fully completed within 30 days of authorization for Medicaid reimbursement.

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

7. Such service-specific provider [~~assessments~~ intakes] shall be performed by an LMHP [~~as defined in 12VAC35-105-20~~, an LMHP-supervisee, LMHP-resident, or LMHP-RP].

8. If an individual receiving therapeutic behavioral services for children and adolescents under 21 (Level B) is also receiving case management services, the therapeutic behavioral services provider must collaborate with the care coordinator/case manager by notifying him of the provision of Level B services and the Level B 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, shall] inform him of the individual's receipt of these Level B 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 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.]

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

12VAC30-60-143. Mental health services utilization criteria; definitions.

A. This section sets out the utilization criteria and standards relative to the community mental health services set out in 12VAC30-50-226. [~~This section also contains definitions for the~~ The] following words and terms [~~which~~ when used in this section] shall have the following meanings unless the context indicates otherwise:

"Licensed mental health professional" or "LMHP" means the same as defined in [~~12VAC35-105-20~~ 12VAC30-50-130.

"LMHP-resident" or "LMHP-R" means the same as defined in 12VAC30-50-130.

"LMHP-resident in psychology" or "LMHP-RP" means the same as defined in 12VAC30-50-130.

"LMHP-supervisee in social work," "LMHP-supervisee," or "LMHP-S" means the same as defined in 12VAC30-50-130.]

"Qualified mental health professional-adult" or "QMHP-A" means the same as defined in [~~12VAC35-105-20~~ 12VAC30-50-130].

"Qualified mental health professional-child" or "QMHP-C" means the same as defined in [~~12VAC35-105-20~~ 12VAC30-50-130].

["Qualified mental health professional-eligible" or "QMHP-E" means the same as defined in [~~12VAC35-105-20~~ 12VAC30-50-130.]

~~A.~~ B. Utilization reviews shall include determinations that providers meet the following requirements:

1. The provider shall meet the federal and state requirements for administrative and financial management capacity. The provider shall obtain, prior to the delivery of services, and shall maintain and update periodically as the Department of Medical Assistance Services (DMAS) or its contractor requires, a current provider enrollment agreement for each Medicaid service that the provider offers. DMAS shall not reimburse providers who do not enter into a provider enrollment agreement for a service prior to offering that service.

2. The provider shall document and maintain individual case records in accordance with state and federal requirements.

3. The provider shall ensure eligible ~~recipients~~ individuals have free choice of providers of mental health services and other medical care under the Individual Service Plan.

4. 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. Providers whose contracts are terminated shall be afforded the right of appeal pursuant to the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia).

5. If an individual receiving community mental health rehabilitative services is also receiving case management services pursuant to 12VAC30-50-420 or 12VAC30-50-430, the provider shall collaborate with the case manager by notifying the case manager of the provision of community mental health rehabilitative services and sending monthly updates on the individual's treatment status. A discharge summary shall be sent to the care coordinator/case manager within 30 calendar days of the discontinuation of services. [Service 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 this documentation into the electronic health record.]

6. The provider shall determine who the primary care provider is and inform him of 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.

7. The provider shall include the individual and the family/caregiver, as may be appropriate, in the development of the ISP. To the extent that the individual's condition requires assistance for participation, assistance shall be provided. The ISP shall be updated annually or as the needs and progress of the individual changes. An ISP that is not updated either annually or as the treatment interventions based on the needs and progress of the individual [~~changes~~ change] shall be considered outdated. An ISP that does not include all required elements specified in 12VAC30-50-226 shall be considered incomplete. All ISPs shall be completed, signed, and contemporaneously dated by the [LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP,] QMHP-A [~~or~~,] QMHP-C [~~as defined in 12VAC35-105-20~~ ~~]~~, [or QMHP-E] preparing the ISP within a maximum of 30 days of the date of the completed [~~assessment~~ intake] unless otherwise specified. The [child's or adolescent's] ISP shall also be signed by the parent/legal guardian and [the adult] individual [shall sign his own]. [~~Documentation shall be provided if the individual, who is a minor child, is unable or unwilling to sign the ISP.~~ If the individual, whether a child, adolescent, or an adult, is unwilling to sign the ISP, then the service provider shall document the clinical or other reasons why the individual was not able or willing to sign the ISP. Signatures shall be obtained unless there is a clinical reason that renders the individual unable to sign the ISP.]

[~~C. Direct clinical services provided on a part-time basis will be reviewed by DMAS or its contractor based on the number of hours provided and counted based upon how many full-time (40 hours) weeks of service were provided.~~]

~~B.~~ [~~D.~~ C.] Day treatment/partial hospitalization services shall be provided following a ~~diagnostic~~ service-specific provider [~~assessment~~ intake] and be authorized by the ~~physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, or licensed clinical nurse specialist-psychiatric~~ LMHP [~~as defined in 12VAC35-105-20~~, LMHP-supervisee, LMHP-resident, or LMHP-RP]. An ISP, as defined in 12VAC30-50-226, shall be fully completed, signed, and dated by either the LMHP [~~or~~, LMHP-supervisee, LMHP-resident, LMHP-RP,] the ~~QMHP~~ QMHP-A, [~~as defined~~ QMHP-E, or QMHP-C and reviewed/approved by the LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP] ~~at 12VAC30-50-226~~ [~~in 12VAC35-105-20,~~] within 30 days of service initiation.

1. The enrolled provider of day treatment/partial hospitalization shall be licensed by ~~DMHMRSAS~~ DBHDS as providers of day treatment services.

2. Services shall only be provided by an LMHP, [LMHP-supervisee, LMHP-resident, or LMHP-RP,] ~~a QMHP~~ QMHP-A, QMHP-C, [QMHP-E,] or a qualified paraprofessional under the supervision of a ~~QMHP~~ QMHP-A, QMHP-C, [QMHP-E,] or an LMHP [~~as defined at 12VAC30-50-226 in 12VAC35-105-20~~, LMHP-supervisee, LMHP-resident, or LMHP-RP].

3. The program shall operate a minimum of two continuous hours in a 24-hour period.

4. Individuals shall be discharged from this service when other less intensive services may achieve or maintain psychiatric stabilization.

~~C.~~ [~~E.~~ D.] Psychosocial rehabilitation services shall be provided to those individuals who have experienced long-term or repeated psychiatric hospitalization, or who experience difficulty in activities of daily living and interpersonal skills, or whose support system is limited or nonexistent, or who are unable to function in the community without intensive intervention or when long-term services are needed to maintain the individual in the community.

1. Psychosocial rehabilitation services shall be provided following ~~an~~ a service-specific provider [~~assessment which~~ intake that] clearly documents the need for services. ~~The~~ This [~~assessment~~ intake that] shall be completed by either an LMHP, ~~or a QMHP, and~~ [~~QMHP-A, or QMHP-C. If the service-specific provider assessment is done by a QMHP-A or a QMHP-C, it shall be approved by a an LMHP within 30 calendar days of admission to services~~ LMHP-supervisee, LMHP-resident, or LMHP-RP]. An ISP shall be completed by either the LMHP [, LMHP-supervisee, LMHP-resident, or LMHP-RP,] or the ~~QMHP~~ QMHP-A [, QMHP-E, or QMHP-C and be reviewed/approved by either an LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP] within 30 calendar days of service initiation. ~~Every~~ At least every three months, the LMHP, [LMHP-supervisee, LMHP-resident, LMHP-RP,] ~~or~~ the ~~QMHP~~ QMHP-A, [~~or the~~] QMHP-C [, or QMHP-E] must review, modify as appropriate, and update the ISP.

2. Psychosocial rehabilitation services of any individual that continue more than six months ~~must~~ shall be reviewed by an LMHP [, LMHP-supervisee, LMHP-resident, or LMHP-RP] who ~~must~~ shall document the continued need for the service. The ISP shall be rewritten at least annually.

3. The enrolled provider of psychosocial rehabilitation services shall be licensed by ~~DMHMRSAS~~ DBHDS as a provider of psychosocial rehabilitation or clubhouse services.

4. Psychosocial rehabilitation services may be provided by [~~either~~] an LMHP, [LMHP-supervisee, LMHP-resident, LMHP-RP,] ~~a QMHP~~ QMHP-A, [~~or,~~] QMHP-C, [QMHP-E,] or a qualified paraprofessional under the supervision of [~~either~~] a ~~QMHP~~ QMHP-A, a QMHP-C, [a QMHP-E,] or an LMHP [, LMHP-supervisee, LMHP-resident, or LMHP-RP].

5. The program shall operate a minimum of two continuous hours in a 24-hour period.

6. Time allocated for field trips may be used to calculate time and units if the goal is to provide training in an integrated setting, and to increase the ~~client's~~ individual's understanding or ability to access community resources.

~~D. Admission to crisis~~ [~~F.~~ E.] Crisis intervention services ~~is~~ shall be indicated following a marked reduction in the individual's psychiatric, adaptive or behavioral functioning or an extreme increase in personal distress.

1. The crisis intervention services provider shall be licensed as a provider of [~~outpatient services~~ emergency services] by ~~DMHMRSAS~~ DBHDS [pursuant to 12VAC35-105-30].

2. Client-related activities provided in association with a face-to-face contact are reimbursable.

3. An [~~Individual Service Plan~~ individual service plan] (ISP) shall not be required for newly admitted individuals to receive this service. Inclusion of crisis intervention as a service on the ISP shall not be required for the service to be provided on an emergency basis.

4. For individuals receiving scheduled, short-term counseling as part of the crisis intervention service, an ISP ~~must~~ shall be developed or revised by the fourth face-to-face contact to reflect the short-term counseling goals ~~by the fourth face-to-face contact~~.

5. Reimbursement shall be provided for short-term crisis counseling contacts occurring within a 30-day period from the time of the first face-to-face crisis contact. Other than the annual service limits, there are no restrictions (regarding number of contacts or a given time period to be covered) for reimbursement for unscheduled crisis contacts.

6. Crisis intervention services may be provided to eligible individuals outside of the clinic and billed, provided the provision of out-of-clinic services is clinically/programmatically appropriate. Travel by staff to provide out-of-clinic services ~~is~~ shall not be reimbursable. Crisis intervention may involve contacts with the family or significant others. If other clinic services are billed at the same time as crisis intervention, documentation must clearly support the separation of the services with distinct treatment goals.

7. An LMHP, [LMHP-supervisee, LMHP-resident, LMHP-RP,] ~~a QMHP~~ [~~QMHP-A, QMHP-C,~~] or a certified prescreener [, as defined in 12VAC30-50-226,] ~~must~~ shall conduct a face-to-face service-specific provider [~~assessment~~ intake]. [~~If the QMHP QMHP-A or QMHP-C performs the service-specific provider assessment, it must be reviewed and approved by an LMHP or a certified prescreener within 72 hours of the face-to-face service-specific provider assessment. The service-specific provider assessment shall document the need for and the anticipated duration of the crisis service.~~] ~~Crisis intervention will be provided by an LMHP, a certified prescreener, or a QMHP.~~

8. Crisis intervention shall be provided by either an LMHP, [LMHP-supervisee, LMHP-resident, LMHP-RP, or] a certified prescreener [~~, a QMHP-A, or a QMHP-C~~].

~~8.~~ [~~9. Crisis intervention shall not require an ISP.~~]

[9. ~~10.~~] For an admission to a freestanding inpatient psychiatric facility for individuals younger than age 21, federal regulations (42 CFR 441.152) require certification of the admission by an independent team. The independent team must include mental health professionals, including a physician. ~~Preadmission~~ These preadmission screenings cannot be billed unless the requirement for an independent team certification, with a physician's signature, is met.

[10. ~~11.~~] Services ~~must~~ shall be documented through daily notes and a daily log of time spent in the delivery of services.

~~E.~~ [~~G.~~ F.] Case management services ~~(pursuant to 12VAC30-50-226)~~ pursuant to 12VAC30-50-420 (seriously mentally ill adults and emotionally disturbed children) or 12VAC30-50-430 (youth at risk of serious emotional disturbance).

1. Reimbursement shall be provided only for "active" case management clients, as defined. An active client for case management shall mean an individual for whom there is ~~a plan of care~~ an ISP in effect ~~which~~ that requires regular direct or client-related contacts or activity or communication with the ~~client~~ individuals or families, significant others, service providers, and others including a minimum of one face-to-face ~~client~~ individual contact within a 90-day period. Billing can be submitted only for months in which direct or client-related contacts, activity, or communications occur.

2. The Medicaid eligible individual shall meet the ~~DMHMRSAS~~ DBHDS criteria of serious mental illness, serious emotional disturbance in children and adolescents, or youth at risk of serious emotional disturbance.

3. There shall be no maximum service limits for case management services. Case management shall not be billed for persons in institutions for mental disease.

4. The ISP ~~must~~ shall document the need for case management and be fully completed within 30 calendar days of initiation of the service~~, and the~~. The case manager shall review the ISP at least every three months. The review will be due by the last day of the third month following the month in which the last review was

completed. A grace period will be granted up to the last day of the fourth month following the month of the last review. When the review was completed in a grace period, the next subsequent review shall be scheduled three months from the month the review was due and not the date of actual review.

5. The ISP shall also be updated at least annually.

6. The provider of case management services shall be licensed by ~~DMHMRSAS~~ DBHDS as a provider of case management services.

~~F.~~ [~~H.~~ G.] Intensive community treatment (ICT) [~~for adults~~].

1. ~~An~~ A service-specific provider [~~assessment which~~ intake that] documents eligibility and the need for this service shall be completed by either the LMHP [, LMHP-supervisee, LMHP-resident, or LMHP-RP] ~~or the QMHP~~ [~~, QMHP-A, or the QMHP-C~~] prior to the initiation of services. This [~~assessment~~ intake] ~~must~~ shall be maintained in the individual's records. Proper completion of the service-specific provider [~~assessment~~ intake] shall comport with the requirements of 12VAC30-50-130.

2. An individual service plan, based on the needs as determined by the service-specific provider [~~assessment~~ intake], must be initiated at the time of admission and must be fully developed by either the LMHP [, LMHP-supervisee, LMHP-resident, LMHP-RP] ~~or the QMHP~~, QMHP-A, [~~or~~] QMHP-C [, or QMHP-E] and approved by the LMHP [, LMHP-supervisee, LMHP-resident, or LMHP-RP] within 30 days of the initiation of services.

3. ICT may be billed if the ~~client~~ individual is brought to the facility by ICT staff to see the psychiatrist. Documentation must be present in the individual's record to support this intervention.

4. The enrolled ICT provider shall be licensed by the ~~DMHMRSAS~~ DBHDS as a provider of intensive community services or as a program of assertive community treatment, and must provide and make available emergency services 24-hours per day, seven days per week, 365 days per year, either directly or on call.

5. ICT services must be documented through a daily log of time spent in the delivery of services and a description of the activities/services provided. There must also be at least a weekly note documenting progress or lack of progress toward goals and objectives as outlined on the ISP.

~~G.~~ [~~I.~~ H.] Crisis stabilization services.

1. This service ~~must~~ shall be authorized following a face-to-face service-specific provider [~~assessment~~ intake] by either an LMHP, [LMHP-supervisee, LMHP-resident, LMHP-RP, or] a certified prescreener, [as defined in 12VAC30-50-226] ~~or~~ [~~a~~] ~~QMHP~~ [~~QMHP-A, or QMHP-C~~]. [~~This assessment must be reviewed and approved by a licensed mental health professional within 72 hours of the assessment.~~]

2. The service-specific provider [~~assessment~~ intake] must document the need for crisis stabilization services [~~and anticipated duration of need~~].

3. The Individual Service Plan (ISP) must be developed or revised within ~~10 business days of the approved assessment or reassessment~~ [~~24 hours~~ three calendar days] of admission to this service. The LMHP, [LMHP-supervisee, LMHP-resident, LMHP-RP,] certified prescreener, QHMP-A, [~~or~~] ~~QMHP~~ QHMP-C [, or QHMP-E] shall develop the ISP.

4. Room and board, custodial care, and general supervision are not components of this service.

5. Clinic option services are not billable at the same time crisis stabilization services are provided with the exception of clinic visits for medication management. Medication management visits may be billed at the same time that crisis stabilization services are provided but documentation must clearly support the separation of the services with distinct treatment goals.

6. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from a condition due to an acute crisis of a psychiatric nature which puts the individual at risk of psychiatric hospitalization.

7. Providers of [residential] crisis stabilization shall be licensed by ~~DMHMRSAS~~ DBHDS as providers of [~~outpatient services~~ mental health residential crisis stabilization]. [Providers of community-based crisis stabilization shall be licensed by DBHDS as providers of mental health nonresidential crisis stabilization.]

~~H.~~ [~~J.~~ I.] Mental health support services. Refer to 12VAC30-50-226 for criteria, service authorization requirements, and service-specific provider [~~assessments~~ intakes] that shall apply for individuals in order to qualify for this service.

1. ~~At~~ Prior to admission, an appropriate face-to-face service-specific provider [~~assessment~~ intake] must be ~~made~~ completed, signed, and dated, and documented by the LMHP [, LMHP-supervisee, LMHP-resident, or LMHP-RP] ~~or the QMHP~~ indicating that service needs can best be met through mental health support services. ~~The assessment must be performed by the LMHP or the QMHP and approved by the LMHP within 30 days of the date of admission. The LMHP or the QMHP will complete the ISP within 30 days of the admission to this service.~~

2. The ISP ~~must~~ , as defined in 12VAC30-50-226, shall be completed, signed, and dated by [either] a [LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP,] QMHP-A [~~or,~~] QMHP-C [, or QMHP-E] within 30 calendar days of service initiation, and shall indicate the specific supports and services to be provided and the goals and objectives to be accomplished. The LMHP [, LMHP-supervisee, LMHP-resident, or LMHP-RP] or ~~QMHP will~~ QMHP-A [, QMHP-C, or QMHP-E] shall supervise the

care if delivered by the qualified paraprofessional. [If the care is supervised by the QMHP-A, QMHP-E, or QMHP-C, then the LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP shall review and approve the supervision of the care delivered by the qualified paraprofessional.]

~~2.~~ 3. Every three months, the LMHP [, LMHP-supervisee, LMHP-resident, LMHP-RP,] ~~or the QMHP must~~ QMHP-A, [~~or~~] QMHP-C [, or QMHP-E] shall review, modify as appropriate, and update the ISP showing a new signature and date of each revision. [If the ISP review is conducted by the QMHP-A, QMHP-C, or QMHP-E, then it shall be reviewed/approved/signed/dated by the LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP.] The ISP ~~must~~ shall be rewritten, signed, and dated by either a QMHP-A, QMHP-C, [~~or~~ QMHP-E,] an LMHP [, LMHP-supervisee, LMHP-resident, or LMHP-RP] at least annually.

~~3.~~ 4. Only direct face-to-face contacts and services to individuals shall be reimbursable.

~~4.~~ 5. Any services provided to the ~~client~~ individual that are strictly academic in nature shall not be billable. These include, but are not limited to, such basic educational programs as instruction in reading, science, mathematics, or the individual's work towards obtaining a GED.

~~5.~~ 6. Any services provided to ~~clients~~ individuals that are strictly vocational in nature shall not be billable. However, support activities and activities directly related to assisting ~~a client~~ an individual to cope with a mental illness to the degree necessary to develop appropriate behaviors for operating in an overall work environment shall be billable.

~~6.~~ 7. Room and board, custodial care, and general supervision are not components of this service.

~~7.~~ 8. This service is not billable for individuals who reside in facilities where staff are expected to provide such services under facility licensure requirements.

~~8.~~ 9. Provider qualifications. The enrolled provider of mental health support services ~~must~~ shall be licensed by ~~DMHMRSAS~~ DBHDS as a provider of supportive in-home services, intensive community treatment, or as a program of assertive community treatment. Individuals employed or contracted by the provider to provide mental health support services ~~must~~ shall have training in the characteristics of mental illness and appropriate interventions, training strategies, and support methods for persons with mental illness and functional limitations.

~~9.~~ 10. Mental health support services, which continue for six consecutive months, ~~must~~ shall be reviewed and renewed at the end of the six-month period of authorization by an LMHP [, LMHP-supervisee, LMHP-resident, or LMHP-RP] who ~~must~~ shall document the continued need for the services.

~~10.~~ 11. Mental health support services ~~must~~ shall be documented through a daily log of time involved in the delivery of services and a minimum of a weekly summary note of services provided.

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

Part XVII
Marketing of Provider Services

12VAC30-130-2000. Marketing requirements and restrictions.

A. Purpose. The purpose of these rules shall be to define how providers shall be permitted to market their services to potential Medicaid or FAMIS beneficiaries and individuals who may or may not be currently enrolled with the particular provider. This shall apply to providers of community mental health services (12VAC30-50-226) and Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) community mental health services (12VAC30-50-130) with the exception of Part C services.

B. Definitions.

"Beneficiaries" means individuals of any age and their families who are using or who may use community mental health rehabilitative services.

"DMAS" means the Department of Medical Assistance Services.

"FAMIS" means Family Access to Medical Insurance Security.

["Marketing materials" means any material created to promote services through any media including, but not limited to, written materials, television, radio, websites, and social media.]

"Provider" means an individual or organizational entity that is appropriately licensed as required and enrolled as a DMAS provider of community mental health and substance abuse services.

C. Requirements.

1. Marketing and promotional activities (including provider promotional activities) shall comply with all [~~relevant~~ applicable] federal and state laws.

2. Providers shall provide clearly written materials that completely and accurately describe the Medicaid or FAMIS behavioral health service or services offered, the beneficiary eligibility requirements to receive the service or services, applicable fees and other charges, and all other information required for beneficiaries and their families to make fully informed decisions about enrollment into the service or services offered by the provider that is marketing its services.

3. Providers shall distribute their marketing materials only in the service locations approved within the license issued by the Licensing Division of the Department of Behavioral Health and Developmental Services.

4. Providers shall receive DMAS approval of all marketing materials and all changes to prior-approved marketing materials prior to their use or dissemination. Providers shall receive the DMAS marketing plan approval before engaging in any marketing activity.

a. Within 30 calendar days of receipt of providers' submissions, DMAS shall review submitted individual marketing materials and services and either approve them or deny their use or direct that specified modifications be made.

b. Providers failing to implement DMAS' required changes, or those which use [unapproved or] disapproved materials, shall be subject to termination of the provider agreement pursuant to 12VAC30-130-2000 E.

D. Limits and prohibitions.

1. Providers shall not offer cash or [~~other~~] noncash incentives to their enrolled or prospective members for the purposes of marketing, retaining beneficiaries within the providers' services, or rewarding behavior changes in compliance with goals and objectives stated in beneficiaries' individual service plans.

2. While engaging in marketing activities, providers shall not:

a. Engage in any marketing activities that could misrepresent the service or DMAS;

b. Assert or state that the beneficiary must enroll with the provider in order to prevent the loss of Medicaid or FAMIS benefits;

c. Conduct door-to-door, telephone, unsolicited school presentations, or other cold call marketing directed at potential or current beneficiaries;

d. Conduct any marketing activities or use marketing materials that are not specifically approved by DMAS;

e. Make home visits for direct or indirect marketing or enrollment activities except when specifically requested by the beneficiary or family;

f. Collect or use Medicaid or FAMIS confidential information or Medicaid or FAMIS protected health information (PHI), as that term is defined in Health Insurance Portability and Accountability Act of 1996 (HIPPA), that may be either provided by another entity or obtained by marketing provider, to identify and market services to prospective beneficiaries;

g. Violate the confidential information or confidentiality of PHI by sharing or selling or sharing lists of information about beneficiaries for any purposes other than the performance of the provider's obligations relative to its DMAS provider agreement;

h. Contact, after the effective date of disenrollment, beneficiaries who choose to disenroll from the provider except as may be specifically required by DMAS;

i. Conduct service assessment or enrollment activities at any marketing or community event; or

j. Assert or state (either orally or in writing) that the provider is endorsed either by the Centers for Medicare and Medicaid Services, DMAS, or any other federal or state governmental entities.

E. Termination. Providers [~~who~~ that (i)] conduct any marketing activity, that is not specifically approved by DMAS [~~or who~~, (ii)] violate any of the [~~above~~] prohibitions [in this section,] or [(iii) fail to meet] requirements shall be subject to termination of their provider agreements for the services affected by the marketing plan/activity. [Providers whose contracts are terminated shall be afforded the right of appeal pursuant to the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia).]

Part XVIII
Behavioral Health Services

12VAC30-130-3000. Behavioral health services.

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

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

12VAC30-130-3010. Definitions.

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

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

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

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

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

"DMAS" means the Department of Medical Assistance Services.

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

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

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

12VAC30-130-3020. Independent clinical assessment requirements [; behavioral health level of care determinations and service eligibility].

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

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

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

B. Independent clinical assessment requirements.

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

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

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

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

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

authorization or reauthorization request being returned to the provider.

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

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

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

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

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

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

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

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

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

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

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

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

4. The independent assessor shall enter the findings of the ICA into the DMAS service authorization contractor's web portal within one business day of conducting the assessment. The independent clinical assessment form (VICAP-001) shall be completed by the independent assessor within three business days of completing the ICA.

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

12VAC30-130-3030. Application to services.

A. Intensive in-home (IIH) services.

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

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

B. Therapeutic day treatment (TDT) [services].

1. Prior to the provision of TDT services, an independent clinical assessment shall be conducted by a person who meets the licensed mental health professional definition found at 12VAC35-105-20 and who is employed by or

contracted with a BHSA, CSB, BHA, or the subcontractor of the BHSA, CSB, or BHA in accordance with DMAS approval.

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

C. Mental health support services (MHSS).

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

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

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

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

FORMS (12VAC30-130)

Forms accompanying Part II of this chapter:

Virginia Uniform Assessment Instrument.

Forms accompanying Part III of this chapter:

MI/MR Supplement Level I (form and instructions).

MI/MR Supplement Level II.

Forms accompanying Part VII of this chapter:

Request for Hospice Benefits DMAS-420, Revised 5/91.

Forms accompanying Part VIII of this chapter:

Inventory for Client and Agency Planning (ICAP) Response Booklet, D9200/D9210, 1986.

Forms accompanying Part IX of this chapter:

Patient Information form.

Instructions for Completion DMAS-122 form.

Forms accompanying Part XII of this chapter:

Health Insurance Premium Payment (HIPP) Program Insurance Information Request Form.

Health Insurance Premium Payment (HIPP) Program Medical History Form (HIPP Form-7, Rev. 11/92).

Health Insurance Premium Payment (HIPP) Program Employers Insurance Verification Form (HIPP Form-2, Rev. 11/92).

Health Insurance Premium Payment (HIPP) Program Employer Agreement (HIPP Form-3, Rev. 11/92).

Health Insurance Premium Payment (HIPP) Program Notice of HIPP Determination (HIPP Form-4, Rev. 11/92).

Health Insurance Premium Payment (HIPP) Program Notice of HIPP Approval.

Health Insurance Premium Payment (HIPP) Program Notice of HIPP Status (HIPP Form-6, Rev. 11/92).

Inventory for Client and Agency Planning (ICAP) Response Booklet, D9200/D9210, 1986.

Forms accompanying Part XIV of this chapter:

Residential Psychiatric Treatment for Children and Adolescents, FH/REV (eff. 10/20/99).

Forms accompanying Part XV of this chapter:

Treatment Foster Care Case Management Agreement, TFC CM Provider Agreement DMAS-345, FH/REV (eff. 10/20/99).

Forms accompanying Part XVIII of this chapter:

Virginia Independent Clinical Assessment Program (VICAP) (eff. 6/11).

VA.R. Doc. No. R11-2790; Filed December 10, 2014, 10:01 a.m.

Emergency Regulation

Titles of Regulations: **12VAC30-50. Amount, Duration, and Scope of Medical and Remedial Care Services (adding 12VAC30-50-600).**

12VAC30-121. Medicare-Medicaid Demonstration Waiver (adding 12VAC30-121-10 through 12VAC30-121-250).

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

Effective Dates: December 10, 2014, through June 9, 2016.

Agency Contact: Matthew Behrens, Project Manager, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 625-3673, FAX (804) 786-1680, or email matthew.behrens@dmas.virginia.gov.

Preamble:

Section 2.2-4011 of the Code of Virginia states that agencies may adopt emergency regulations in situations in which Virginia statutory law or the appropriation act or federal law or federal regulation requires that a regulation be effective in 280 days or less from its enactment, and the regulation is not exempt under the provisions of § 2.2-4006 A 4 of the Code of Virginia.

Item 307 RR of Chapter 806 of the 2013 Acts of Assembly, the 2013 Appropriation Act, directed the Department of

Medical Assistance Services (DMAS) to implement a care coordination program for a Medicare-Medicaid dual eligible enrollee. Item 307 AAAA of the Act directed DMAS to implement a process for administrative appeals of Medicaid/Medicare dual eligible recipients in accordance with the terms of the Memorandum of Understanding between DMAS and the Centers for Medicare and Medicaid Services for the Virginia Medicare-Medicaid Financial Alignment Demonstration Model. Item 307 RRRR of the Act provides for achieving cost savings and standardization of administrative and other processes for providers. The amendments conform regulation to these requirements.

The establishment of Commonwealth Coordinated Care as the mandated care coordination program allows DMAS to combine certain aspects of Medicaid managed care and long-term care and Medicare into one program. The purpose of this regulatory action is to provide integrated care to dual eligible individuals who are currently excluded from participating in managed care programs. This change will enable participants to access their primary and acute medical services, behavioral health services, and long-term care services through a single managed delivery system, thereby increasing the coordination of services across the spectrum of care. The new program offers dual eligible individuals care coordination, health risk assessments, interdisciplinary care teams, and plans of care, which are currently unavailable for this population. Care coordination is essential to providing appropriate and timely services to often-vulnerable participants.

12VAC30-50-600. Section 1932 dual eligible Medicare-Medicaid individuals.

A. Consistent with the Social Security Act § 1932(a)(1)(A) (the Act), the Commonwealth enrolls Medicaid enrollees on a voluntary basis into Medicare-Medicaid Plans (MMPs) in the absence of § 1115 or § 1915(b) waiver authority.

B. Consistent with § 1932(a)(1)(B) of the Act, the Commonwealth shall contract with MMPs. The payment method to the contracting entity shall be a capitation method.

C. The public process used by DMAS for both the design of the program and its initial implementation entailed:

1. DMAS convened public stake holder meetings, in March and July of 2012. Participants were informed and given the opportunity to provide recommendations.

2. DMAS considered these recommendations and incorporated many into its program proposal.

3. DMAS has established an advisory committee that meets quarterly throughout the duration of the program to discuss topics such as program design, educational and outreach materials, and provider and beneficiary issues.

D. Enrollment will be voluntary in the counties and cities designated by the following regions: (i) Central Virginia, (ii) Northern Virginia, (iii) Tidewater, (iv) Western/Charlottesville, and (v) Roanoke.

E. The Commonwealth assures that all of the applicable requirements of § 1903(m) of the Act for MMPs and MMP contracts are met.

F. The Commonwealth assures that all the applicable requirements of § 1932 of the Act for the state's option to limit freedom of choice by requiring enrollees to receive their benefits through managed care entities will be met. MMPs shall be required to pass readiness reviews prior to enrolling individuals.

G. The Commonwealth assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in § 1905(a)(4)(C) of the Act will be met.

H. The Commonwealth assures that all applicable managed care requirements of 42 CFR Part 438 for MMPs will be met. Enrollees shall be permitted to opt out at any time with or without cause from the program pursuant to 42 CFR 438.56(c).

I. The Commonwealth assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.

J. The Commonwealth assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.

K. Eligible groups.

1. No groups shall be enrolled on a mandatory basis. Enrollment shall be voluntary.

2. Enrollees shall also be eligible for Medicare. Full-benefit dual eligible (eligible for both Medicare and Medicaid) individuals ages 21 years and older who are eligible for the program shall be passively enrolled. Individuals shall have 60 days after notification of program enrollment to opt out before they are passively enrolled into an MMP. Individuals shall be permitted to change MMPs or opt out of the program and return to fee-for-service services at any time. With the exception of the following, individuals shall be allowed to reenroll in the program at any time:

a. Individuals who are in hospice shall be excluded from enrolling in the program. If an enrollee is in the program and then enters hospice care, he shall be disenrolled from the program. If such an individual elects to leave hospice, he will be permitted to reenroll in the program.

b. Individuals who receive the Medicare end stage renal disease (ESRD) benefit after enrolling in the program shall be permitted to remain in the program. If such individuals opt out of the program, they shall not be permitted to re-enroll.

L. Pursuant to § 1932(a)(2) of the Act, the Commonwealth provides that full-benefit dual eligible individuals based on

their eligibility for Medicare Parts A, B, and D and for full Medicaid benefits, also known as Qualified Medicare Beneficiaries (QMB) Plus individuals, are exempt from mandatory enrollment into this program's managed care.

M. Enrollment process.

1. DMAS shall use a preassignment algorithm, through its Medicaid Management Information System (MMIS), and a contracted enrollment broker to facilitate the continuity of care of Medicaid individuals by providers that have traditionally served this population.

2. DMAS shall not use a lock in for managed care pursuant to 42 CFR 438.50.

3. Individuals shall have 60 days to choose a health plan before being automatically assigned.

4. Eligible individuals will receive a notice that indicates to which MMP they have been assigned. The notice will have instructions for the individual to contact the DMAS contracted enrollment broker to:

a. Accept the preassigned MMP;

b. Select a different MMP that is operating in their region; or

c. Opt out of the program altogether and stay in the fee-for-service environment. If an individual does not select an MMP, he shall be passively enrolled into the preassigned MMP.

5. Enrollees shall be assigned to an MMP based on six months of claims prior to preassignment using the rules below in order of priority:

a. Individuals in a nursing facility shall be preassigned to an MMP that includes the individual's nursing facility in its provider network;

b. Individuals in the EDCD Waiver shall be assigned to an MMP that includes the individual's current adult day health care provider in its provider network;

c. If more than one MMP network includes the nursing facility or adult day healthcare provider used by an individual, the individual will be assigned to the MMP with which he has previously been assigned in the past six months. If he has no history of previous MMP assignment, he shall be randomly assigned to an MMP in which his provider participates.

d. Individuals shall be preassigned to an MMP with whom they have previously been assigned within the past six months.

N. The Commonwealth assures that it has an enrollment system that allows individuals who are already enrolled to be given priority to continue that enrollment if the MMP does not have capacity to accept all who are seeking enrollment under the program.

O. The Commonwealth assures that, pursuant to the choice requirements in 42 CFR 438.52, Medicaid individuals who are enrolled in an MMP will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).

P. The Commonwealth shall apply the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the individual is disenrolled solely because he loses Medicaid eligibility for a period of two months or less.

Q. The following services shall be excluded from coverage by the MMP in this program:

1. Induced abortions;

2. Targeted case management; and

3. Dental services (see 12VAC30-121-70 for specific coverage).

R. The Commonwealth shall intentionally limit the number of entities it contracts with under the option permitted by § 1932 of the Act. The Commonwealth assures that such limits on the number of contracting entities shall not substantially impair enrollee access to services.

CHAPTER 121
MEDICARE-MEDICAID DEMONSTRATION WAIVER

12VAC30-121-10. Demonstration waiver program authority.

A. Medicare authority. The Medicare elements of the program shall operate according to existing Medicare Parts C and D laws and regulations, as amended or modified, except to the extent these requirements are waived or modified as provided for in the memorandum of understanding (MOU) between the Centers for Medicare and Medicaid Services (CMS) and the department. As a term and condition of the program, participating plans will be required to comply with Medicare Advantage and Medicare Prescription Drug Program requirements in Part C and Part D of Title XVIII of the Social Security Act (the Act) and 42 CFR Parts 422 and 423, as amended from time to time, except to the extent specified in the MOU for waivers and the three-way contract.

B. Medicaid authority. The Medicaid elements of the program shall operate according to existing Medicaid laws and regulations, including but not limited to all requirements of the § 1915(c) of the Act waivers for individuals enrolled in the Elderly or Disabled with Consumer Direction (EDCD) Waiver, as amended or modified, except to the extent waived as provided for in the MOU. As a term and condition of the program, the Commonwealth and participating plans shall comply with Medicaid managed care requirements under Title XIX of the Act and 42 CFR Part 438, other applicable regulations, as amended or modified, except to the extent specified in the MOU, and the three-way contract. The Commonwealth will add concurrent authority to the relevant § 1915(c) programs via amendments in the next update or scheduled renewal, whichever occurs sooner.

C. CMS reserves the right to withdraw programs or expenditure authorities at any time it determines that continuing the programs or expenditure authorities are no longer in the public interest or promote the objectives of Title

XVIII of the Social Security Act. CMS will promptly (i) notify DMAS in writing of the determination, the reasons for the withdrawal, and the effective date and (ii) subject to § 1115A(d)(2) of the Social Security Act, afford DMAS a reasonable opportunity to request a reconsideration of the CMS determination prior to the effective date.

D. Termination and phase out would proceed as described in § III L of the MOU between CMS and DMAS. If a program or expenditure authority is withdrawn, federal financial participation (FFP) is limited to normal closeout costs associated with terminating the program or expenditure authority, including covered services and administrative costs of disenrolling enrollees.

12VAC30-121-20. Definitions.

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

"Action" means, consistent with 42 CFR 438.400, an action by the participating plan, subcontractor, service provider, or Virginia Department of Medical Assistance Services that constitutes a denial or limited authorization of a service authorization request, including (i) type or level of service; (ii) reduction, suspension, or termination of a previously authorized service; (iii) failure to act on a service request; (iv) denial in whole or in part of a payment for a covered service; (v) failure by the participating plan to render a decision within the required timeframes; or (vi) denial of an enrollee's request to exercise his right under 42 CFR 438.52(b)(2)(ii) to obtain services outside of the network.

"Appellant" means an applicant for or recipient of Medicaid benefits who seeks to challenge an action taken by the participating plan regarding eligibility for services and payment determinations.

"CPT" means Current Procedural Terminology, Revised 2014, as published by the American Medical Association.

"Capitation payment" means a payment the department makes periodically to a participating plan on behalf of each enrollee enrolled under a contract for the provision of services under the state plan and waivers, regardless of whether the enrollee receives services during the period covered by the payment.

"Capitation rate" means the monthly amount payable to the plan per enrollee for the provision of contract services. The plans shall accept the established capitation rates paid each month by the department and CMS as payment in full for all Medicaid and Medicare services to be provided pursuant to the three-way contract and all associated administrative costs, pending final recoupment, reconciliation, sanctions, or payment of quality withhold amounts.

"Care management" means the collaborative, person-centered process that assists enrollees in gaining access to needed health care services and includes (i) assessing for and planning of health care services; (ii) linking the enrollee to services and supports identified in the plan of care; (iii) working with the enrollee directly for the purpose of locating, developing, or obtaining needed health care services and resources; (iv) coordinating health care services and service planning with other agencies, providers, and family members involved with the enrollee; (v) making collateral contacts to promote the implementation of the plan of care and community integration; (vi) monitoring to assess ongoing progress and ensuring services are delivered; and (vii) education and counseling that guides the enrollee and develops a supportive relationship that promotes the plan of care.

"Carved-out services" means the subset of Medicaid and Medicare covered services for which the plan shall not be fiscally responsible under the demonstration.

"Centers for Medicare and Medicaid Services" or "CMS" means the federal agency of the United States Department of Health and Human Services that is responsible for the administration of Titles XVIII, XIX, and XXI of the Social Security Act.

"Commonwealth Coordinated Care," "CCC," or "the program" means the program for the Virginia Medicare-Medicaid Financial Alignment Demonstration Model.

"Cost sharing" means copayments, coinsurance, or deductibles paid by an enrollee when receiving medical services.

"Covered enrollee" means an enrollee enrolled in the demonstration, including the duration of any month in which his eligibility for the demonstration ends.

"Covered services" means the set of required services offered by the participating plan as set forth in the three-way contract.

"Cultural competency" means understanding those values, beliefs, and needs that are associated with an enrollee's age, gender identity, sexual orientation, or racial, ethnic, or religious background. Cultural competency (i) includes a set of competencies that are required to ensure appropriate, culturally sensitive health care to persons with congenital or acquired disabilities and (ii) is based on the premise of respect for enrollee and cultural differences and on an implementation of a trust-promoting method of inquiry and assistance.

"Demonstration" means the capitated model under the Medicare-Medicaid Financial Alignment Demonstration Model as authorized by the Centers for Medicare and Medicaid Services (CMS) and as set out in the Patient Protection and Affordable Care Act of 2010 and authorized under § 1115A of the Social Security Act. The demonstration requires compliance with (i) Title XIX of the Social Security Act and Medicaid regulations set forth in 42 CFR Chapter IV, (ii) Part C of Title XVIII and Medicare Advantage regulations set forth in 42 CFR Part 4224, and (iii) Part D of Title XVIII and Medicare Part D regulations set forth in 42 CFR Part

4236, except to the extent that waivers and variances are documented in the memorandum of understanding (MOU) between CMS and DMAS. Under the demonstration, states, CMS, and participating plans will enter into three-way contracts through which the plans will receive a capitated rate to cover the full continuum of Medicare and Medicaid benefits provided to dual eligible enrollees. Demonstrations will be for the period as outlined in the MOU, unless terminated earlier as provided for in § 1115A of the Social Security Act, the MOU, and the three-way contract.

"Department of Medical Assistance Services," "the department," or "DMAS" means the Virginia Department of Medical Assistance Services, the single state agency for the Medicaid program in Virginia that is responsible for implementation and oversight of the demonstration.

"Disenrollment" means the process of changing enrollment from one participating plan to another participating plan or returning from the participating plan to the fee-for-service system but shall not include ending eligibility in the Medicare or Medicaid programs.

"Division" or "Appeals Division" means the Appeals Division of the Department of Medical Assistance Services.

"Dual eligible enrollees" means a Medicare enrollee who receives (i) Medicare Parts A, B, and D benefits and also receives full Medicaid benefits and (ii) does not meet any exclusionary reasons as outlined in the MOU. This term will be used to reference enrollees who are eligible for the demonstration.

"Effective date of enrollment" means the date on which a participating plan's coverage begins for an enrollee.

"Elderly or Disabled with Consumer Direction Waiver" or "EDCD Waiver" means, as provided in Part IX (12VAC30-120-900 et seq.) of Waivered Services (12VAC30-120) the CMS-approved waiver that covers a limited range of community support services offered to enrollees who are elderly or who have a disability and meet Virginia nursing facility level of care criteria as set out in 12VAC30-60-300, 12VAC30-60-303, and 12VAC30-60-307.

"Enrollee" means a person eligible for full Medicaid benefits and Medicare Parts A, B and D who is also enrolled in a participating plan to receive services under the demonstration.

"Enrollee appeal" means an enrollee's request for review of a participating plan's coverage or payment determination. In accordance with 42 CFR 438.400, a Medicaid-based appeal is defined as a request for review of an action. An appeal is an enrollee's challenge to the actions regarding services, benefits, and reimbursement provided by the participating plan, its service providers, or the Department of Medical Assistance Services.

"Enrollee communications" means the materials designed to communicate to enrollees plan benefits, policies, processes, and enrollee rights, including pre-enrollment, post-enrollment, and operational materials.

"Enrollment" means the completion of approved enrollment forms by or on behalf of an eligible person and assignment of an enrollee to a participating plan by DMAS in accordance with federal law.

"Enrollment facilitator" means an independent entity contracted with DMAS that (i) enrolls beneficiaries in the plan, (ii) is responsible for the operation and documentation of a toll-free helpline, (iii) educates enrollees about the plan, (iv) assists with and tracks enrollees' grievance resolutions, and (v) may market and perform outreach to potential enrollees.

"Enrollment period" means the time that an enrollee is actually enrolled in a participating plan.

"Evidence of coverage" or "EOC" means a document, prepared by the MMP and provided to the enrollee that is consistent with the requirements of 42 CFR 438.10, 42 CFR 422.11, and 42 CFR 423.128 and includes information about all the services covered by that plan.

"Expedited appeal" means the process by which the department must respond to an appeal by an enrollee if a denial of care decision and the subsequent internal appeal by a participating plan may jeopardize life, health, or ability to attain, maintain, or regain maximum function.

"External appeal" means an appeal, subsequent to the participating plan appeal decision, to the state fair hearing process for Medicaid-based adverse decisions or to the Medicare process for Medicare-based adverse decisions. The department's external appeal decision shall be binding upon the participating plan or plans and not subject to further appeal by the participating plan or plans.

"Fee-for-service" or "FFS" means the traditional health care payment system in which physicians and other providers receive a payment for each service they provide.

"Fiscal/employer agent" or "F/EA" means an organization (i) operating under § 3504 of the IRS Code, IRS Revenue Procedure 70-6, and IRS Notice 2003-70 and (ii) that has a separate federal employer identification number used for the sole purpose of filing federal employment tax forms and payments on behalf of program enrollees who are receiving consumer-directed services.

"Final decision" means a written determination by a hearing officer that is binding on the department, unless modified during or after the judicial process and that may be appealed to the local circuit court.

"Full benefit dual eligible" means an enrollee defined as Dual Eligible-QMB-plus pursuant to 12VAC30-10-320 A.

"Good cause" means to provide sufficient cause or reason for failing to file a timely appeal or for missing a scheduled appeal hearing.

"Health risk assessment" or "HRA" means a comprehensive assessment of an enrollee's medical, psychosocial, cognitive, and functional status in order to determine his medical,

behavioral health, long-term care services and supports, and social needs.

"Hearing" means an informal evidentiary proceeding conducted by a department hearing officer during which an enrollee has the opportunity to present his concerns with, or objections to, the participating plan's internal appeal decision.

"Hearing officer" means an impartial decision maker who conducts evidentiary hearings for enrollee appeals on behalf of the department.

"Home and community-based waiver services" or "waiver services" means a variety of home and community-based services eligible for payment by DMAS as authorized under a § 1915(c) waiver designed to offer enrollees an alternative to institutionalization.

"ICF/IID" means an intermediate care facility for individuals with intellectual disabilities.

"Integrated appeals process" means the process that incorporates relevant Medicare and Medicaid requirements and allows enrollees to appeal actions for either Medicare-based services or Medicaid-based services to the MMP with one request.

"Interdisciplinary care team" or "ICT" means a team of professionals who collaborate, either in person or through other means, with the enrollee to develop and implement (employing both medical and social models of care) a plan of care that meets the enrollee's medical, behavioral health, long-term care services and supports, and social needs. ICTs may include physicians, physician assistants, long-term care providers, nurses, specialists, pharmacists, behavior health specialists, and social workers, as may be appropriate for the enrollee's medical diagnoses and health condition, comorbidities, and community support needs.

"Intermediate sanctions" means sanctions that may be imposed on the Medicare-Medicaid Plans (MMP) such as civil money penalties, appointment of temporary management, permission for individuals to terminate enrollment in the Medicare-Medicaid Plan without cause, suspension or default of all enrollment of individuals, and suspension of payment to the Medicare-Medicaid Plan for individuals enrolled pursuant to 42 USC § 1396u-2(e)(2).

"Internal appeal" means an enrollee's initial request for review of a participating plan's coverage or payment determination by his MMP.

"Long-stay hospitals" mean specialty Medicaid facilities that serve enrollees who require a higher intensity of nursing care than that which is normally provided in a nursing facility and who do not require the degree of care and treatment that an acute care hospital is designed to provide.

"Long-term services and supports" or "LTSS" means a variety of services and supports that (i) help elderly enrollees and enrollees with disabilities who need assistance to perform activities of daily living and instrumental activities of daily living to improve the quality of their lives and (ii) are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. Examples of these activities include assistance with bathing, dressing, and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping, and transportation.

"Medicaid" means the program of medical assistance benefits under Title XIX of the Social Security Act and various demonstrations and waivers thereof.

"Medically necessary" or "medical necessity" means, per Medicare, services that are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 USC § 1395y. Per Virginia Medicaid, an item or service provided for the diagnosis or treatment of a patient's condition consistent with community standards of medical practice and in accordance with Medicaid policy (12VAC30-130-600). Furthermore, as defined in 42 CFR 440.230, services must be sufficient in amount, duration, and scope to reasonably achieve their purpose. Services must be provided in a way that provides all protections to covered enrollees provided by Medicare and Virginia Medicaid.

"Medicare" means Title XVIII of the Social Security Act, the federal health insurance program for people age 65 or older, people younger than 65 years of age who have certain disabilities, and people with end stage renal disease (ESRD) or amyotrophic lateral sclerosis (ALS).

"Medicare independent review entity" means an independent organization contracted by CMS to review appeals for Medicare-covered services that have been denied by the enrollee's MMP

"Medicare-Medicaid enrollees" means, for the purposes of this demonstration, enrollees who are (i) entitled to Medicare Part A and enrolled in Medicare Parts B and D (ii) receive full benefits under the Virginia State Plan for Medical Assistance, and (iii) otherwise meet eligibility criteria for the demonstration.

"Medicare Part A" means hospital insurance that helps cover inpatient care in hospitals, skilled nursing facilities, hospice, and home health care.

"Medicare Part B" means insurance that helps cover medically necessary services such as doctors services, outpatient care, durable medical equipment, home health services, other medical services, and some preventive services.

"Medicare Part C" or "Medicare Advantage" means plans that (i) provide all of an enrollee's Medicare Part A and Medicare Part B coverage; (ii) may offer extra coverage, such as vision, hearing, dental, or health and wellness programs; and (iii) may include Medicare prescription drug coverage (Part D).

"Medicare Part D" means Medicare prescription drug coverage.

"Memorandum of understanding" or "MOU" means the Memorandum of Understanding between the Centers for Medicare and Medicaid Services (CNS) and the Commonwealth of Virginia Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees (5/2013), the document that sets out the mutually agreed to understanding of this program between CMS and DMAS.

"Minimum Data Set" or "MDS" means part of the federally-mandated process for assessing enrollees receiving care in certified skilled nursing facilities in order to record their overall health status, regardless of payer source.

"Model of care" means a comprehensive plan that (i) describes the plan's population; (ii) identifies measurable goals for providing high quality care and improving the health of the enrolled population; (iii) describes the plan's staff structure and care management roles; (iv) describes the interdisciplinary care team and the system for disseminating the model of care to plan staff and network providers; and (vi) contains other information designed to ensure that the plans provide services that meet the needs of enrollees.

"Money Follows the Person" or "MFP" means a demonstration project administered by DMAS that is designed to create a system of long-term services and supports that better enable enrollees to transition from certain long-term care institutions into the community.

"Network" means doctors, hospitals, or other health care providers that participate or contract with a participating plan and, as a result, agree to accept a mutually-agreed upon payment amount or fee schedule as payment in full for covered services that are rendered to eligible enrollees.

"Nursing facility" means any skilled nursing facility, skilled care facility, intermediate care facility, nursing care facility, or nursing facility, whether freestanding or a portion of a freestanding medical care facility, that is certified for participation as a Medicare or Medicaid provider, or both, pursuant to Title XVIII and Title XIX of the United States Social Security Act, as amended, and § 32.1-137 of the Code of Virginia.

"Opt-out option" means the process by which an enrollee can choose to not participate in the demonstration.

"Participating plan," "Medicare-Medicaid Plan," or "MMP" means a health plan selected to participate in Virginia's Medicare-Medicaid Financial Alignment Demonstration Model and that is a party to the three-way contract with CMS and DMAS.

"Passive enrollment" means an enrollment process through which an eligible enrollee is enrolled by DMAS (or its vendor) into a participating plan, when not otherwise affirmatively electing one following a minimum 60-day advance notification that includes the opportunity to make another enrollment decision or opt out of the demonstration prior to the enrollment effective date.

"Plan of care" or "POC" means a plan, primarily directed by the enrollee and family members of the enrollee as appropriate with the assistance of the enrollee's interdisciplinary care team to meet the enrollee's medical, behavioral health, long-term care services and supports, and social needs.

"Preadmission screening" means the process to (i) evaluate the functional, nursing, and social supports of enrollees referred for preadmission screening; (ii) assist enrollees in determining what specific services the enrollees need; (iii) evaluate whether a service or a combination of existing community services are available to meet the enrollees' needs; and (iv) refer enrollees to the appropriate entity for either Medicaid-funded nursing facility services or home and community-based care for those enrollees who meet the criteria for nursing facility level of care.

"Preadmission screening team" means the entity contracted with DMAS that is responsible for performing preadmission screening pursuant to § 32.1-330 of the Code of Virginia.

"Previously authorized" means, in relation to continuation of benefits, as described in 42 CFR 438.420, a prior approved course of treatment and is best clarified by the following example: If the plan authorizes 20 visits and then later reduces this authorization to 10 visits, this exemplifies a "previously authorized service" that is being reduced. Conversely, "previously authorized" does not include the following example: (i) the plan authorizes 10 visits; (ii) the 10 visits are rendered; and (iii) another 10 visits are requested but are denied by the plan. In this case, the fact that the plan had authorized 10 visits on a prior request for authorization is not germane to continuation of benefits requirements for previously authorized services that are terminated, suspended, or reduced.

"Primary care provider" or "PCP" means a practitioner who provides preventive and primary medical care and certifies service authorizations and referrals for medically necessary specialty services. PCPs may include pediatricians, family and general practitioners, internists, obstetrician/gynecologists, geriatricians, and specialists who perform primary care functions (such as surgeons) and clinics including, but not limited to, local health departments, federally qualified health centers (FQHCs), rural health clinics (RHCs).

"Privacy" means the requirements established in the Health Insurance Portability and Accountability Act of 1996, and implementing regulations, Medicaid regulations, including 42 CFR 431.300 through 431.307, as well as relevant Virginia privacy laws.

"Program of All-Inclusive Care for the Elderly" or "PACE" means the program in which the PACE provider provides the entire spectrum of health services (preventive, primary, and acute) and long-term services and supports to its enrollees

without limit as to duration or cost of services pursuant to 12VAC30-50-320 et seq.

"Provider appeal" means an appeal filed by a Medicare, Medicaid or other service provider that has already provided a service and has received an action regarding payment or audit result.

"Quality withhold amounts" means percentages of the respective components, with the exception of Medicare Part D amounts, of the capitation rate due to the participating plans to be retained by CMS and DMAS until such time as the plan's performance is consistent with established quality thresholds.

"Remand" means the return of a case by the hearing officer to the participating plan for further review, evaluation, and action.

"Remote patient monitoring" means monitoring a patient remotely and is often used for patients with one or more chronic conditions, such as congestive heart failure, cardiac arrhythmias, diabetes, pulmonary diseases, or the need for anticoagulation treatment and must be agreed to by the enrollee. Examples of remote patient monitoring activities include, but are not limited to, transferring vital signs such as weight, blood pressure, blood sugar, and heart rate from the enrollee to the physician's office.

"Representative" means an attorney or other individual who has been authorized to represent an enrollee pursuant to these regulations.

"Reverse" means to overturn the participating plan's action and internal appeal decision and to direct that the participating plan fully approve the amount, duration, and scope of requested services.

"Secretary" means the Secretary of the U.S. Department of Health and Human Services.

"Social Security Act" means the federal act, codified through Chapter 7 of Title 42 of the United States Code, that established social insurance programs including Medicare and Medicaid.

"Spend down" means when a Medicaid applicant meets all Medicaid eligibility requirements other than income, Medicaid eligibility staff conduct a "medically needy" calculation that compares the enrollee's income to a medically needy income limit for a specific period of time referred to as the "budget period" (not to exceed six months). When a Medicaid applicant's incurred medical expenses equal the spend down amount, the applicant is eligible for full benefit Medicaid for the remainder of the spend down budget period.

"State fair hearing" means the DMAS evidentiary hearing process as administered by the Appeals Division of DMAS.

"State Plan for Medical Assistance" or "State Plan" means the comprehensive written statement submitted to CMS by the department describing the nature and scope of the Virginia Medicaid program and giving assurance that it will be administered in conformity with the requirements, standards, procedures, and conditions for obtaining federal financial participation. DMAS has the authority to administer such State Plan for the Commonwealth pursuant to the authority of the § 32.1-325 of the Code of Virginia, as amended.

"Store and forward" means when prerecorded images, such as x-rays, video clips, and photographs are captured and then forwarded to and retrieved, viewed, and assessed by a provider at a later time. Some common applications include: (i) teledermatology, where digital pictures of a skin problem are transmitted and assessed by a dermatologist; (ii) teleradiology, where x-ray images are sent to and read by a radiologist; and (iii) teleretinal imaging, where images are sent to and evaluated by an ophthalmologist to assess for diabetic retinopathy.

"Sustain" means to uphold the participating plan's appeal decision.

"Targeted case management" or "TCM" means the Medicaid-funded State Plan case management service provided by private providers for enrollees with substance use disorders or developmental disabilities and by community services boards or behavioral health authorities for enrollees with behavioral health disorders or intellectual disabilities, and encompasses both referral and transition management and clinical services such as monitoring, self-management support, and medication review and adjustment. TCM is separate from "care management" as defined in the MOU.

"Telehealth" or "telemedicine" means the real time or near real time two-way transfer of data and information using an interactive audio/video connection for the purposes of medical diagnosis and treatment.

"Three-way contract" means the three-way agreement between CMS, DMAS, and a participating plan specifying the terms and conditions pursuant to which a participating plan shall participate in CCC.

"Uniform Assessment Instrument" or "UAI" means the standardized multidimensional questionnaire that is completed by a preadmission screening team, or a hospital discharge planner for applicants residing in a hospital setting, that assesses an enrollee's psychosocial health, physical health, mental health, and functional abilities to determine if an applicant meets level of care criteria for long-term services and supports that are funded through Medicaid.

"Vulnerable subpopulation" means, at a minimum, individuals from the following groups: (i) individuals who are enrolled in the Elderly or Disabled with Consumer Direction (EDCD) Waiver (12VAC30-120-900 et seq.); (ii) individuals who have either intellectual or developmental disabilities, or both; (iii) individuals who have cognitive or memory problems, or both, (e.g., dementia and traumatic brain injury); (iv) individuals with physical or sensory disabilities; (v) individuals who are residing in nursing facilities; (vi) individuals who have serious and persistent mental illness or illnesses; (vii) individuals who have end stage renal disease;

and (viii) individuals who have complex or multiple chronic health conditions, or both.

"Withdrawal" means a written request from the enrollee or the enrollee's representative for the department to terminate the appeal process without a final decision on the merits.

12VAC30-121-30. Selected localities.

A. The demonstration shall operate in specific regions within the Commonwealth.

B. The department and CMS will implement the demonstration in Central Virginia, Northern Virginia, Roanoke, Tidewater, and Western/Charlottesville regions.

C. Under the demonstration, DMAS will conduct a regional phase-in. Phase I will impact Central Virginia and Tidewater. Phase II will impact Western/Charlottesville, Northern Virginia, and Roanoke.

D. Participating plans must cover all eligible enrollees in all localities within the region or regions in which such plans participate.

12VAC30-121-40. Eligible enrollees.

A. Medicaid-eligible enrollees who qualify as follows may be eligible to be enrolled in the demonstration:

1. Individuals who are 21 years of age and older at the time of enrollment;

2. Individuals who are entitled to benefits under Medicare Part A, enrolled under Medicare Parts B and D, and who are receiving full Medicaid benefits. This includes enrollees participating in the EDCD Waiver and those residing in nursing facilities;

3. Individuals who reside in a program region; and

4. Individuals who do not meet any of the exclusions identified in 12VAC30-121-45.

B. Individuals who have been excluded from CCC, for any reason, shall be permitted to opt in to the program once the reason for their exclusion no longer exists.

12VAC30-121-45. Individuals excluded from enrollment.

Individuals who meet at least one of the following criteria shall be excluded from the program:

1. Individuals who are younger than 21 years of age.

2. Individuals who are required to "spend down" income in order to meet Medicaid eligibility requirements.

3. Individuals for whom DMAS only pays a limited amount each month toward their cost of care (e.g., deductibles), including non-full-benefit Medicaid beneficiaries. These Individuals may receive Medicaid coverage for the following: (i) Medicare monthly premiums for Medicare Part A, Medicare Part B, or both (carved-out payment); (ii) coinsurance, copayment, and deductible for Medicare-allowed services; and (iii) Medicaid-covered services, including those that are not covered by Medicare.

These individuals may include:

a. Qualified Medicare Beneficiaries (QMBs);

b. Special Low Income Medicare Beneficiaries (SLMBs);

c. Qualified Disabled Working Individuals (QDWIs); or

d. Qualifying Individuals (QIs).

4. Individuals who are inpatients in state mental hospitals, including but not limited to Catawba Hospital, Central State Hospital, Eastern State Hospital, Hiram W. Davis Medical Center, Northern Virginia Mental Health Institute, Piedmont Geriatric Hospital, Southern Virginia Mental Health Institute, Southwestern State HM&S, Southwestern Virginia Mental Health Institute, Western State HM&S, and Western State Hospital.

5. Individuals who are residents of state hospitals, ICF/IID facilities, residential treatment facilities, or long stay hospitals.

6. Individuals who are participating in federal waiver programs for home and community-based Medicaid coverage other than the EDCD Waiver (e.g., Individual and Family Developmental Disabilities Support, Intellectual Disability, Day Support, Technology Assisted Waiver, and Alzheimer's Assisted Living Waivers).

7. Individuals receiving hospice services at the time of enrollment will be excluded from the program. If an enrollee enters a hospice program while enrolled in the waiver, he will be disenrolled from the program. If such enrollees opt out of this program, they shall not be permitted to reenter it. If enrollees do not opt out but leave this program due to program action, they shall be permitted to return to the program upon their leaving the hospice program. However, participating plans shall refer these individuals to the preadmission screening team for additional LTSS if not already in place.

8. Individuals receiving the end stage renal disease (ESRD) Medicare benefit at the time of enrollment into the program. However, an enrollee who develops ESRD while enrolled in the waiver will remain in the program unless he opts out. If he opts out, the enrollee shall not be permitted to opt back into the program.

9. Individuals with other comprehensive group or enrollee health insurance coverage, other than full benefit Medicare, insurance provided to military dependents, and any other insurance purchased through the Health Insurance Premium Payment Program.

10. Individuals who have a Medicaid eligibility period that is less than three months.

11. Individuals who have a Medicaid eligibility period that is only retroactive.

12. Individuals 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.

13. Individuals enrolled in the MFP program.

14. Individuals residing outside of the program coverage regions.

15. Individuals enrolled in a Program of All-Inclusive Care for the Elderly (PACE). However, PACE participants may enroll in the waiver if they choose to disenroll from their PACE provider.

16. Individuals participating in the CMS Independence at Home (IAH) demonstration or any other demonstration that bases some or all payment on achievement of Medicare savings.

12VAC30-121-50. Enrollment process.

Individuals who qualify as indicated in 12VAC30-121-40 and are not excluded as provided in 12VAC30-121-45 shall be enrolled as follows, except if they choose to opt out:

1. Enrollees shall be assigned to a participating plan based on their previous six months of Medicaid claims history prior to preassignment using the rules in this order of priority:

a. Enrollees in a nursing facility shall be preassigned to a participating plan that includes the enrollee's nursing facility in its provider network;

b. Enrollees in the EDCD Waiver shall be assigned to a participating plan that includes the enrollee's current adult day health care provider in the MMP's existing provider network;

c. If more than one participating plan network includes the nursing facility or adult day health care provider used by an enrollee, he shall be assigned to the participating plan with which he has previously been assigned in the past six months. If he has no history of previous participating plan assignment, he shall be randomly assigned to a participating plan in which his provider participates.

d. Enrollees shall be preassigned to a participating plan, first the Medicare plan and secondly the Medicaid participating plan, with whom they have previously been assigned within the past six months.

2. Utilizing passive enrollment, eligible enrollees will be notified of their right to select among contracted participating plans no fewer than 60 days prior to the effective date of enrollment.

3. Eligible enrollees shall receive a notice that indicates the participating plan to which they have been preassigned. The notice shall have instructions for the enrollee to contact the department's contracted enrollment broker to (i) accept the preassigned participating plan; (ii) select a different participating plan that is operating in their region; or (iii) to opt out of the program and remain in the fee-for-service environment. If an enrollee does not select a participating plan, he shall be passively enrolled into the preassigned participating plan.

4. Prior to the effective date of their plan enrollment, enrollees who would be passively enrolled will have the opportunity to opt out and will receive sufficient notice and information with which to do so.

5. All enrollment effective dates shall be prospective. Enrollee-elected enrollment is effective the first day of the month following an enrollee's request to enroll, so long as the request is received on or before five days before the end of the month. Enrollment requests, including requests to change among participating plans, received later than five days before the end of the month, will become effective the first of the second month following the request. Passive enrollment is effective not sooner than 60 days after enrollee notification.

6. Disenrollment from participating plans and transfers between participating plans shall be allowed on a month-to-month basis any time during the year; however, coverage for these enrollees will continue through the end of the month. All disenrollment requests will be effective the first day of the month following an enrollee's request to disenroll from the CCC Program.

7. CMS and DMAS will monitor enrollments and disenrollments for both evaluation purposes and for compliance with applicable marketing and enrollment laws, regulations, and CMS policies, for the purposes of identifying any inappropriate or illegal marketing practices. As part of this analysis, CMS and DMAS will monitor any unusual shifts in enrollment by enrollees identified for passive enrollment into a particular participating plan to a Medicare Advantage plan operated by the same parent organization. If those shifts appear to be due to inappropriate or illegal marketing practices, CMS or DMAS, or both, may require corrective action. Any illegal marketing practices will be referred to appropriate agencies for investigation.

8. As mutually agreed upon in the three-way contract, CMS and DMAS shall utilize an independent third party entity to facilitate all enrollments into the participating plans.

9. Participating plan enrollments, transfers, and opt-outs shall become effective on the same day for both Medicare and Medicaid. For enrollees who lose Medicaid eligibility during a month, coverage and federal financial participation will continue through the end of the month in which Medicaid eligibility is ended.

12VAC30-121-60. (Reserved.)

12VAC30-121-70. Covered services.

A. CMS and DMAS shall contract with participating plans that demonstrate the capacity to provide directly, or by subcontracting with other qualified entities, the full continuum of medically necessary Medicare and Medicaid covered services to enrollees, in accordance with (i) the MOU; (ii) CMS guidance; (iii) the three-way contract; (iv) 42

CFR Part 422, 42 CFR Part 423, and 42 CFR Part 438; (v) the requirements in the State Plan for Medical Assistance, including any applicable State Plan amendments and § 1915(c) of the Act; (vi) the EDCD Waiver (12VAC30-120-900 et seq.); (vii) 42 USC § 1395y; (viii) 12VAC30-130-600; (ix) the ADA; and (x) the Olmstead decision (Olmstead v. L.C. (98-536) 527 U.S. 581 (1999)). Furthermore, as defined in 42 CFR 440.230, services shall be sufficient in amount, duration, and scope to reasonably achieve their purpose. Participating plans shall be required to provide services in a way that preserves all protections to enrollees and provides enrollees with coverage to at least the same extent provided by Medicare and Medicaid. Where there is overlap between Medicare and Medicaid benefits, coverage and rules shall be delineated in the three-way contract. Participating plans will be required to abide by the more generous of the applicable Medicare, Medicaid, or the combined Medicare-Medicaid standard.

B. With the exception of those services that are specifically carved out of this program as set out in subdivision C of this section, the required covered services shall include, but not be limited to:

1. Medicare Parts A, B, and D services.

2. Medically necessary procedures. Participating plans will be responsible for medically necessary procedures, including but not limited to, the following:

a. CPT codes billed for dental services performed as a result of a dental accident (i.e., an accident that damages the mouth);

b. Preparation of the mouth for radiation therapy, maxillary or mandibular frenectomy when not related to a dental procedure, orthognathic surgery to attain functional capacity, and surgical services on the hard or soft tissue in the mouth where the main purpose is not to treat or help the teeth and their supporting structures.

c. Anesthesia and hospitalization for medically necessary services.

d. At their option, additional flexible dental services for program enrollees.

e. For participants of auxiliary grants, case management services. Although not widely used, this service is included as part of the annual reassessment screening process for assisted living recipients and will be provided under fee-for-service.

3. Acute care services provided under the State Plan for Medical Assistance as found in 12VAC30-50, and further defined by written DMAS regulations, policies, and instructions, except as otherwise modified or excluded in the three-way contract;

4. Covered LTSS provided under the EDCD Waiver, including adult day health care, personal care (agency and consumer-directed options), personal emergency response services with or without medication monitoring, respite care (agency and consumer-directed options), transition coordination, and transition service.

5. The integrated formulary for prescription drugs, including Medicaid-covered drugs that are excluded by Medicare Part D. Participating plans must also cover drugs covered by Medicare Parts A or B. In all respects, unless stated otherwise in the MOU or the three-way contract, Medicare Part D requirements continue to apply.

6. Nursing facility services as defined in 42 CFR 440.40.

7. Health risk assessments.

a. Each enrollee shall receive and be an active participant in a timely, comprehensive, assessment of medical, behavioral health, LTSS, and social needs completed by the participating plan's care management team. All health risk assessment tools are subject to approval by DMAS. Assessment domains will include, but not be limited to, the following: medical, psychosocial, functional, cognitive, and behavioral health. Relevant and comprehensive data sources, including the enrollee, providers, family, caregivers, and additional significant others as may be designated by the enrollee, shall be used by the participating plans.

b. During the first year of the program, all enrollees meeting any of the following criteria shall receive a health risk assessment to be completed no later than 60 days from the onset of these enrollees' enrollment:

(1) Individuals enrolled in the EDCD Waiver;

(2) Individuals with intellectual or developmental disabilities;

(3) Individuals with cognitive or memory problems (e.g., dementia or traumatic brain injury);

(4) Individuals with physical or sensory disabilities;

(5) Individuals residing in nursing facilities;

(6) Individuals with serious and persistent mental illnesses;

(7) Individuals with end stage renal disease; and

(8) Individuals with complex or multiple chronic health conditions.

c. During the first year of the program and for all other enrollees, health risk assessments must be conducted within 90 days of enrollment.

d. Health risk assessments for individuals enrolled in the EDCD Waiver and for individuals residing in nursing facilities must be conducted face to face. The health risk assessments for individuals residing in nursing facilities must also incorporate the MDS.

e. During subsequent years of the program, individuals enrolled in the EDCD Waiver must receive a health risk assessment within 30 days of enrollment and all other enrollees must receive a health risk assessment within 60 days of enrollment.

8. Level of care (LOC) determinations.

a. Initial LOC determinations shall be conducted by hospitals and local preadmission screening teams as defined in § 32.1-330 of the Code of Virginia.

b. Participating plans must ensure that LOC annual reassessments are conducted timely for EDCD Waiver participants (minimum within 365 days of the last annual reassessment or as the participants' needs change). Participating plans shall conduct annual face-to-face assessments for continued nursing facility LOC eligibility requirements for the EDCD Waiver.

c. The plans shall establish criteria that includes health status change (i.e., the triggering events that precipitate a need for reassessment, including a change in the ability to perform activities of daily living and instrumental activities of daily living) for reassessments to be performed prior to the reassessment.

d. The LOC annual reassessment shall include all the elements required by the three-way contract for enrollees who are in the EDCD Waiver who have a change in status.

e. LOC annual reassessments for EDCD Waiver enrollees shall be performed by providers with the following qualifications: (i) a registered nurse (RN) licensed in Virginia with at least one year of experience as an RN; (ii) a social worker licensed in Virginia; or (iii) an individual who holds at least a bachelor's degree in a health or human services field and has at least two years of experience working with individuals who are elderly or have disabilities, or both.

f. Participating plans shall ensure that quarterly and annual assessments are conducted timely for nursing facility residents based on the MDS process and shall work cooperatively with nursing facilities to provide information regarding the completion of the assessments for continued nursing facility placement.

g. Participating plans shall communicate annual LOC reassessment data for EDCD Waiver enrollees and nursing facility residents to DMAS according to requirements in the three-way contract.

9. Plans of care (POCs).

a. Participating plans shall develop a person-centered POC for each enrollee. The POC shall be tailored to the individual enrollee's needs and be agreed to and signed by the enrollee or the enrollee's employer of record.

b. Participating plans shall implement a person-centered and culturally competent POC development process. Participating plans shall also develop a process that will incorporate but not duplicate targeted case management for applicable enrollees.

c. During the first year of the CCC, participating plans shall ensure that plans of care for all enrollees are completed within 90 days of the enrollees' enrollment. Participating plans shall honor all existing plans of care and service authorizations until the authorization ends or 180 days from enrollees' enrollment, whichever is sooner. For EDCD Waiver individuals, the plan of care shall be developed and implemented by the participating plan no later than the end date of any existing service authorization.

d. During subsequent years of the program, participating plans shall ensure that plans of care are developed within the following timeframes:

(1) Within 30 days of enrollment for EDCD Waiver participants;

(2) Within 60 days of enrollment for vulnerable subpopulations (excluding EDCD Waiver participants); and

(3) Within 90 days of enrollment for all other enrollees.

e. Participating plans shall incorporate information from the UAI and the LOC determinations into the POCs for individuals in the EDCD Waiver.

f. Participating plans shall develop a process for obtaining nursing facility MDS data and incorporating that information into the POC. Participating plans shall ensure that nursing facilities' residents who wish to move to the community will be referred to the preadmission screening teams or the MFP program. If the individual enrolls in the MFP program, he will be disenrolled from this program.

g. Participating plans shall develop a process for addressing health, safety (including minimizing risk), and welfare of the enrollee in the POC.

h. The POC shall contain the following:

(1) Prioritized list of enrollee's concerns, needs, and strengths;

(2) Attainable goals, outcome measures, and target dates selected by the enrollee or caregiver, or both;

(3) Strategies and actions, including interventions and services to be implemented, the providers responsible for specific interventions and services, and the frequency of the interventions and strategies;

(4) Progress noting success, barriers, or obstacles;

(5) Enrollee's informal support network and services;

(6) Back up plans as appropriate for EDCD Waiver enrollees using personal care and respite services in the event that the scheduled provider or providers are unable to provide services;

(7) Determined need and plan to access community resources and noncovered services;

(8) Enrollee choice of services (including consumer-direction) and service providers; and

(9) Elements included in the DMAS-97AB form, (which can be downloaded from

https://www.virginiamedicaid.dmas.virginia.gov/wps/portal) for individuals enrolled in the EDCD Waiver.

i. Participating plans shall ensure that reassessments and POC reviews are conducted:

(1) By the POC anniversary for vulnerable subpopulations (excluding EDCD Waiver participants and nursing facility residents) and all other enrollees;

(2) By the POC anniversary, not to exceed 365 days for EDCD Waiver enrollees (must be face to face); and

(3) Following MDS guidelines and timeframes for quarterly and annual POC development for nursing facility residents.

j. Participating plans must ensure that POCs are revised based on triggering events, such as hospitalizations or significant changes in health or functional status.

10. Interdisciplinary care team (ICT).

a. For each enrollee, participating plans shall support an ICT to ensure the integration of the enrollee's medical, behavioral health, substance use, LTSS, and social needs. The team will be person centered, built on the enrollee's specific preferences and needs, and deliver services with transparency, individualization, respect, linguistic and cultural competency, and dignity.

b. Participating plans ICTs shall employ both medical and social models of care, as appropriate for their enrollees' documented needs.

c. Participating plan members of the team shall agree to participate in approved training on the person-centered planning processes, cultural competency, accessibility and accommodations, independent living and recovery, ADA/Olmstead requirements, and wellness principles, along with other required training as specified by the Commonwealth. Participating plans will offer training to additional members of the team such as primary care providers and specialists, as appropriate.

d. If an enrollee is receiving Medicaid State Plan for Medical Assistance targeted case management services, the participating plans shall develop a mechanism to include the targeted case manager as a member of the ICT.

e. If an enrollee is identified to be eligible to transition into the community through the Department of Justice Settlement Agreement (Case: 3:12-CV-00059-JAG, available at http://www.dbhds.virginia.gov/settlement/FullAgreement.pdf), the participating plan's ICT shall collaborate with the locality's community services board (CSB) or behavioral health authority, as appropriate, and the Department of Behavioral Health and Developmental Services to successfully transition the enrollee into the community. The enrollee's CSB case manager shall participate as a part of the participating plan's ICT to monitor the enrollee's service needs. If the enrollee transitions into either the Individuals with Intellectual Disabilities Waiver or Developmental Disability Waiver, the enrollee shall be disenrolled from this program. If the enrollee transitions to the EDCD Waiver, the enrollee may remain in the program.

11. State requirements for care coordination.

a. The participating plan shall provide person-centered care management functions for all enrollees.

b. All enrollees shall have access to the following supports depending on their needs and preferences; however, care management for vulnerable subpopulations shall include the items described below in subdivisions (6) through (12):

(1) A single, toll-free point of contact for all questions;

(2) Ability to develop, maintain and monitor the POC;

(3) Assurance that referrals result in timely appointments;

(4) Communication and education regarding available services and community resources;

(5) Assistance developing self-management skills to effectively access and use services;

(6) Assistance in receiving needed medical and behavioral health services, preventive services, medications, LTSS, social services, and enhanced benefits; this includes (i) setting up appointments, (ii) in-person contacts as appropriate, (iii) strong working relationships between care managers and physicians; (iv) evidence-based enrollee education programs, and (v) arranging transportation as needed;

(7) Monitoring of functional and health status;

(8) Seamless transitions of care across specialties and care settings;

(9) Assurance that enrollees with disabilities have effective communication with health care providers and participate in making decisions with respect to treatment options;

(10) Connecting enrollees to services that promote community living and help avoid premature or unnecessary nursing facility placements;

(11) Coordination with social service agencies (e.g., local departments of health, local departments of social services, and community services boards) and referrals for enrollees to state, local, and other community resources; and

(12) Collaboration with nursing facilities to promote adoption of evidence-based interventions to reduce avoidable hospitalizations and to include management of chronic conditions, medication optimization, prevention of falls and pressure ulcers, and coordination of services beyond the scope of the nursing facility benefit.

c. Participating plans shall develop innovative arrangements to provide care management such as:

(1) Partnering or contracting, or both, with entities, such as community services boards, adult day care centers, and nursing facilities, that currently perform care management and offer support services to individuals eligible for the program;

(2) Medical homes;

(3) Subcapitation, such as payment arrangement where the MMP pays its contracted providers on a capitated basis rather than a fee-for-service basis;

(4) Shared savings; and

(5) Performance incentives.

d. Participating plans and DMAS shall collaborate to avoid duplication of care management services provided under the program.

e. Participating plans shall be required to use one statewide F/EA to manage the F/EA services for individuals using consumer direction.

12. Participating plans shall be permitted to use and reimburse telehealth for Medicare and Medicaid services as an innovative, cost effective means to decrease hospital admissions, reduce emergency department visits, address disparities in care, increase access, and increase timely interventions. Participating plans shall also encourage the use of telehealth to promote community living and improve access to behavioral health services. Participating plans shall be permitted to use telehealth in rural and urban settings and reimburse for store and forward applications. Participating plans shall also have the ability to cover remote patient monitoring. All telehealth and remote patient monitoring activities shall be compliant with HIPAA requirements and will be further outlined in the three-way contract.

13. Skilled nursing level care may be provided in a long-term care facility without a preceding acute care inpatient stay for enrollees enrolled in the program when the provision of this level of care can avert the need for an inpatient hospital stay.

C. The following services shall be carved out of the program and provided under the fee-for-service system:

1. Abortions, induced (this service shall be provided under limited circumstances, e.g., when the life of the mother is endangered, through fee-for-service);

2. Targeted case management services (these services will be provided under fee-for-service) and;

3. Dental services (in limited cases, these services will be provided under fee-for-service).

12VAC30-121-75. Flexible benefits.

A. Flexible benefits are those that MMPs may elect to offer to their enrollees.

B. Examples of such benefits are (i) annual physical examinations, (ii) meal benefits, (iii) preventive and comprehensive dental services for adults, (iv) eye examinations, (v) prescription eyeglasses, (vi) hearing examinations, and (vii) hearing aids.

12VAC30-121-80. (Reserved.)

12VAC30-121-90. Capitation payment rates.

A. Capitation rates and payment rules shall be established in the MOU and three-way contract and may be adjusted by state or federal regulatory changes.

B. If other state or federal statutory changes enacted after the annual baseline determination and rate development process are jointly determined by CMS and DMAS to have a material change in baseline estimates for any given payment year, baseline estimates and corresponding standardized payment rates shall be updated outside of the annual rate development process.

C. Any and all costs incurred by the participating plan in excess of the capitation payment shall be borne in full by the plan.

D. Additional costs shall not be balance billed to the plan's enrollees.

12VAC30-121-100. (Reserved.)

12VAC30-121-110. Cost sharing requirements.

A. Participating plans shall not charge a Medicare Part C or D premium nor assess any cost sharing for Medicare Parts A and B services.

B. For drugs and pharmacy products (including those covered by both Medicare Part D and Medicaid), participating plans shall be permitted to charge co-pays to enrollees currently eligible to make such payments consistent with co-pays applicable for Medicare and Medicaid drugs, respectively. Co-pays charged by participating plans for Part D drugs shall not exceed the applicable amounts for brand and generic drugs established yearly by CMS under the Part D Low Income Subsidy. Plans may elect to reduce this cost sharing for all enrollees as a way of testing whether reducing enrollee cost sharing for pharmacy products improves health outcomes and reduces overall health care expenditures through improved medication adherence under the waiver.

C. Patient pay requirements, which are applicable to long term-care services, shall be detailed in the contract between CMS, DMAS, and the participating plans.

D. Participating plans shall not assess any cost sharing for DMAS services, beyond the pharmacy cost sharing amounts allowed under Medicaid coverage rules.

E. No enrollee may be balance billed by any provider for any reason for covered services or flexible benefits (see 12VAC30-121-75).

12VAC30-121-120. (Reserved.)

12VAC30-121-130. Access standards.

A. Participating plans shall have the capacity to provide, directly or by subcontracting with other qualified entities, the full continuum of Medicare and Medicaid covered services to enrollees, in accordance with the MOU, CMS guidance, and the three-way contract.

B. Network adequacy. State Medicaid standards shall be utilized for long-term services and supports or for other services for which Medicaid is exclusively responsible for payment, and Medicare standards shall be utilized for pharmacy benefits and for other services for which Medicare is primary, unless applicable Medicaid standards for such services are more stringent. Home health and durable medical equipment requirements, as well as any other services for which Medicaid and Medicare may overlap, shall be subject to the more stringent of the applicable Medicare and Medicaid standards.

C. Participating plans shall ensure that they maintain a network of providers that is sufficient in number, mix of primary care and specialty providers, and geographic distribution to meet the complex and diverse needs of the anticipated number of enrollees in the service area as defined by CMS for Medicare and defined by DMAS for Medicaid.

D. For services for which Medicaid is the traditional primary payer (including, but not limited to, LTSS and community mental health and substance abuse services), each enrollee shall have a choice of at least two providers of each covered service type located within no more than 30 minutes travel time from any enrollee in urban areas unless the participating plan has a DMAS-approved alternative time standard. Travel time shall be determined based on driving during normal traffic conditions (i.e., not during commuting hours).

E. The participating plan shall ensure that each enrollee shall have a choice of at least two providers of each covered service type located within no more than 60 minutes travel time from any enrollee in rural areas unless the participating plan has a DMAS-approved alternative time standard.

F. DMAS shall require contractual agreements between nursing facilities and participating plans. Payment for services shall be made to nursing facilities directly by the participating plans. Participating plans will be required to contract with any nursing facility that is eligible to participate in Medicare and Medicaid and is willing to accept the participating plan payment rates and contract requirements for the time duration of the demonstration period.

G. For any covered services for which Medicare requires a more rigorous network adequacy standard than Medicaid (including time, distance, or minimum number of providers or facilities), the participating plan shall meet the Medicare requirements.

12VAC30-121-140. MMPs having low performance.

A. Provided that the MMP is determined by DMAS to meet all plan selection requirements in the three-way contract, an interested organization that (i) is an outlier in the CMS past performance analysis for the upcoming contract year, (ii) has a low performance indicator (LPI) on the Medicare Plan Finder website for the upcoming year, or (iii) both may qualify to offer CCC services.

B. Such MMPs shall not be eligible to receive passive enrollment until the MMP is either (i) no longer considered by CMS to be a past performance outlier or (ii) no longer has an LPI on the Medicare Plan Finder.

C. CMS or DMAS, or both, shall determine if an MMP is eligible to accept passive enrollment prior to the scheduled date of execution of the three-way contract.

D. An MMP that is ineligible to receive passive enrollment shall only be able to enroll (i) individuals who are currently enrolled in another Medicare or Medicaid managed care plan sponsored by the same organization and (ii) individuals who opt in to the organization's MMP.

12VAC30-121-145. Sanctions for noncompliance.

A. DMAS may impose intermediate sanctions, which may include any of the types described in subsection C of this section, or terminate the MMP if the MMP:

1. Fails substantially to provide medically necessary items and services that are required under law or under the MMP's contract with DMAS to be provided to an enrollee covered under the contract;

2. Imposes premiums or charges on enrollees in excess of the premiums or charges permitted under this chapter;

3. Acts to discriminate among enrollees on the basis of their health status or requirements for health care services, including expulsion or refusal to reenroll an individual, except as permitted by this chapter, or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the organization by eligible individuals whose medical conditions or histories indicate a need for substantial future medical services;

4. Misrepresents or falsifies information that is furnished to either:

a. The secretary or DMAS under this chapter; or

b. To an enrollee, potential enrollee, or a health care provider under this chapter; or

5. Fails to comply with the applicable requirements of 42 USC § 1396b(m)(2)(A)(x).

B. DMAS may also impose such intermediate sanction against an MMP if DMAS determines that the MMP distributed directly or through any agent or independent contractor marketing materials in violation of 12VAC30-121-250.

C. The sanctions shall be as follows:

1. Civil money penalties:

a. Except as provided in subdivision 1 b, 1 c, or 1 d of this subsection, not more than $25,000 for each determination under subsection A of this section.

b. With respect to a determination under subdivision A 3 or A 4 a of this section, not more than $100,000 for each such determination.

c. With respect to a determination under subdivision A 2 of this section, double the excess amount charged in violation, and the excess amount charged shall be deducted from the penalty and returned to the individual concerned.

d. Subject to subsection 1 b of this subsection, with respect to a determination under subdivision A 3 of this section, $15,000 for each individual not enrolled as a result of a practice described in subdivision A 3.

2. The appointment of temporary management:

a. To oversee the operation of the MMP upon a finding by DMAS that there is continued egregious behavior by the organization or there is a substantial risk to the health of enrollees;

b. To assure the health of the organization's enrollees if there is a need for temporary management while there is an orderly termination or reorganization of the organization; or

c. To make improvements to remedy the violations found under subsection A of this section except that temporary management under this subdivision 2 may not be terminated until DMAS has determined that the MMP has the capability to ensure that the violations shall not recur.

3. Requiring the MMP (i) to permit individuals enrolled with the MMP to terminate enrollment without cause and (ii) to notify such individuals of such right to terminate enrollment.

4. Suspension or default of all enrollment of individuals under this chapter after the date the Secretary or DMAS notifies the MMP of a determination of a violation of any requirement of 42 USC § 1396b(m) or this section.

5. Suspension of payment to the entity under this chapter for individuals enrolled after the date the secretary or DMAS notifies the MMP of such a determination and until the secretary or DMAS is satisfied that the basis for such determination has been corrected and is not likely to recur.

12VAC30-121-150. Continuity of care.

A. As provided by the MOU and the three-way contract, participating plans shall be required to provide or arrange for all medically necessary services, whether by subcontract or by single-case agreement, in order to meet the health care and support needs of their enrollees.

B. Participating plans shall allow enrollees to maintain their current Medicaid providers (including out-of-network providers) for 180 days from enrollment. Participating plans shall also allow enrollees to maintain their preauthorized Medicaid services, including frequency and payment rate, for the duration of the prior authorization or for 180 days from enrollment, whichever is less. This shall not apply to enrollees residing in a nursing facility on the date of each region's program implementation.

C. Enrollees in nursing facilities at the time of program implementation may remain in the facility, or move to another nursing facility, as long as they continue to meet DMAS criteria for nursing facility care. In order to move to another nursing facility, the enrollee or his family, or both as may be appropriate, has to agree to the move.

D. During the 180-day period specified in subsection B of this section, change from an existing Medicaid provider can only occur in the following circumstances:

1. The enrollee requests a change;

2. The provider chooses to discontinue providing services to an enrollee as currently allowed by Medicare or Medicaid;

3. The participating plan, CMS, or DMAS identify provider performance issues that affect the enrollee's health and welfare; or

4. The provider is excluded from participation in Medicare and Medicaid under state or federal exclusion requirements pursuant to the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals or Entities (LEIE) website. Immediately report in writing to DMAS any exclusion information discovered to (i) DMAS, ATTN: Program Integrity/Exclusions, 600 East Broad Street, Suite 1300, Richmond, VA 23219 or (ii) providerexclusion@dmas.virginia.gov;

E. Out-of-network reimbursement rules.

1. In an urgent or emergency situation, participating plans shall reimburse an out-of-network provider of emergency or urgent care at the Medicare or Medicaid FFS rate applicable for that service, or as otherwise required under Medicare Advantage rules for Medicare services. For example, where this service would traditionally be covered under Medicare FFS, the participating plan will pay out-of-network providers the lesser of providers' charges or the Medicare FFS.

2. During the 180-day transition period as outlined in the MOU, the participating plan shall honor existing service authorization timeframes and continue to provide access to the same services and providers at the same levels and rates of Medicare or Medicaid FFS payment (not to exceed 180 days) as enrollees were receiving prior to entering the participating plan.

3. Beyond this six-month period, under certain defined circumstances, participating plans will be required to offer

single-case out-of-network agreements to providers that are currently serving enrollees and are willing to continue serving them at the participating plan's in-network payment rate, but are not willing to accept new patients or enroll in the participating plan's network.

12VAC30-121-170. Model of care.

A. All participating plans (in partnership with contracted providers) shall implement an evidence-based model of care (MOC). Participating plans must meet all CMS MOC standards for Special Needs Plans as well as additional requirements established by the Commonwealth. The Virginia-specific MOC elements are in addition to CMS elements; likewise, the CMS and DMAS reviews and approvals are separate processes. Participating plans shall obtain approvals from both CMS and DMAS before a MOC is considered final and approved.

B. Participating plans shall be permitted to cure problems with their MOC submissions after their initial submissions. Participating plans with MOCs scoring below 85% will have the opportunity to improve their scores based on CMS and DMAS feedback on the elements and factors that require improvement. At the end of the review process, MOCs that do not meet CMS standards for approval will not be eligible for selection as participating plans. CMS standards for approval are issued to the states and made available on the DMAS website at http://www.dmas.virginia.gov/Content_atchs/altc/altc-fp1.pdf.

12VAC30-121-180. (Reserved.)

12VAC30-121-190. State fair hearing process.

A. Notwithstanding the provisions of 12VAC30-110-10 through 12VAC30-110-370, the following regulations govern state fair hearings for dual eligible individuals enrolled in the demonstration.

B. The Appeals Division maintains an appeals and fair hearings system for enrollees (also referred to as appellants) to challenge appeal decisions rendered by participating plans in response to enrollee appeals of actions related to Medicaid services. Exhaustion of the participating plan's appeals process is a prerequisite to filing for a state fair hearing with the department. Appellants who meet criteria for a state fair hearing shall be entitled to a hearing before a department hearing officer.

C. The participating plan shall conduct the initial appeal hearing, pursuant to 42 CFR Part 431 Subpart E, 42 CFR Part 438, and 12VAC30-110-10 through 12VAC30-110-370, and issue a written decision that includes its findings and information regarding the appellant's right to file an appeal with DMAS for a state fair hearing for Medicaid appeals.

D. Enrollees must be notified in writing of the participating plan's integrated appeals process:

1. At the time of the request for services;

2. With the evidence of coverage; and

3. Upon receipt of a notice of action from the participating plan.

E. Enrollees must be notified in writing of their right to an external appeal upon receipt of the participating plan's internal appeal decision.

F. An appellant shall have the right to representation by an attorney or other individual of his choice at all stages of an appeal.

1. For those appellants who wish to have a representative, a representative shall be designated in a written statement that is signed by the appellant whose Medicaid benefits were adversely affected. If the appellant is physically unable to sign a written statement, the division shall allow a family member or other person acting on the appellant's behalf to be the representative. If the appellant is mentally unable to sign a written statement, the division shall require written documentation that a family member or other person has been appointed or designated as his legal representative.

2. If the representative is an attorney or a paralegal working under the supervision of an attorney, a signed statement by such attorney or paralegal that he is authorized to represent the appellant prepared on the attorney's letterhead shall be accepted as a designation of representation.

3. A member of the same law firm as a designated representative shall have the same rights as the designated representative.

4. An appellant may revoke representation by another person at any time. The revocation is effective when the department receives written notice from the appellant.

G. Any written communication from an enrollee or his representative that clearly expresses that he wants to present his case to a reviewing authority shall constitute an appeal request.

1.This communication should explain the basis for the appeal of the participating plan's internal appeal decision.

2. The enrollee or his representative may examine witnesses or documents, or both, provide testimony, submit evidence, and advance relevant arguments during the hearing.

H. Appeals to the state fair hearing process shall be made to the Appeals Division in writing, with the exception of expedited appeals, and may be made via U.S. mail, fax transmission, hand delivery, or electronic transmission.

I. Expedited appeals referenced in subsection L of this section may be filed by telephone, or any of the methods set forth in subsection H of this section.

J. Participating plans shall continue benefits while the participating plan's appeal or the state fair hearing is pending when all of the following criteria are met:

1. The enrollee or representative files the appeal within 10 calendar days of the mail date of the participating plan's internal appeal decision;

2. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

3. The services were ordered by an authorized provider;

4. The original period covered by the initial authorization has not expired; and

5. The enrollee requests continuation of benefits.

K. After the final resolution and if the final resolution of the appeal is adverse to the enrollee (e.g., participating plan's internal appeal is upheld), the participating plan may recover the costs of services furnished to the enrollee while the appeal was pending, to the extent they were furnished solely because of the pending appeal.

L. The department shall maintain an expedited process for appeals when an appellant's treating provider certifies that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function. Expedited appeal decisions shall be issued as expeditiously as the enrollee's health condition requires, but no later than three business days after the agency receives a fair hearing request on an appeal decision to uphold denial of a service that it determines meets the criteria for expedited resolution.

12VAC30-121-195. Appeal timeframes.

A. Appeals to the Medicaid state fair hearing process must be filed with the DMAS Appeals Division within 60 days of the date of the participating plan's internal appeal decision, unless the time period is extended by DMAS upon a finding of good cause in accordance with state fair hearing regulations.

B. It is presumed that appellants will receive the participating plan's internal appeal decision five days after the participating plan mails it.

C. A request for appeal on the grounds that the participating plan has not acted with reasonable promptness in response to an internal appeal request may be filed at any time until the participating plan has acted.

D. The date of filing shall be the date the request is postmarked, if mailed, or the date the request is received by the department, if delivered other than by mail.

E. Documents postmarked on or before a time limit's expiration shall be accepted as timely.

F. In computing any time period under these regulations, the day of the act or event from which the designated period of time begins to run shall be excluded and the last day included. If a time limit would expire on a Saturday, Sunday, or state or federal holiday, it shall be extended until the next regular business day.

G. An extension of the 60-day period for filing a request for appeal may be granted for good cause shown. Examples of good cause include, but are not limited to, the following situations:

1. Appellant was seriously ill and was prevented by illness from contacting DMAS;

2. The participating plan's decision was not sent to the appellant. The plan may rebut this claim by evidence that the decision was mailed to the appellant's last known address or that the decision was received by the appellant.

3. Appellant sent the request for appeal to another government agency or another division within DMAS that is not the Appeals Division in good faith within the time limit; or

4. Unusual or unavoidable circumstances prevented a timely filing.

H. During the first year of the program, appeals shall be heard and decisions issued within 90 days of the postmark date (if delivered by U.S. mail) or receipt date (if delivered by any method other than U.S. mail).

I. The timeframes for issuing decisions will change to 75 days (during the second year of the program), and 30 days (during the third year of the program and thereafter).

J. Exceptions to standard appeal resolution timeframes. Decisions may be issued beyond the standard appeal resolution timeframes when the appellant or his representative requests or causes a delay. Decisions may also be issued beyond the standard appeal resolution timeframe when any of the following circumstances exist:

1. The appellant or representative requests to reschedule or continue the hearing;

2. The appellant or representative provides good cause for failing to keep a scheduled hearing appointment, and the Appeals Division reschedules the hearing;

3. Inclement weather, unanticipated system outage, or the department's closure that prevents the hearing officer's ability to work;

4. Following a hearing, the hearing officer orders an independent medical assessment as described in 12VAC30-121-210;

5. The hearing officer leaves the hearing record open after the hearing in order to receive additional evidence or argument from the appellant;

6. The hearing officer receives additional evidence from a person other than the appellant or his representative and the appellant requests to comment on such evidence in writing or to have the hearing reconvened to respond to such evidence or;

7. The Appeals Division determines that there is a need for additional information and documents how the delay is in the appellant's best interest.

K. For delays requested or caused by an appellant or his representative the delay date for the decision will be calculated as follows:

1. If an appellant or representative requests or causes a delay within 30 days of the request for a hearing, the 90-day time limit will be extended by the number of days from the date when the first hearing was scheduled until the date to which the hearing is rescheduled.

2. If an appellant or representative requests or causes a delay within 31 to 60 days of the request for a hearing, the 90-day time limit will be extended by 1.5 times the number of days from the date when the first hearing was scheduled until the date to which the hearing is rescheduled.

3. If an appellant or representative requests or causes a delay within 61 to 90 days of the request for a hearing, the 90-day time limit will be extended by two times the number of days from the date when the first hearing was scheduled until the date to which the hearing is rescheduled.

L. Post hearing delays requested or caused by an appellant or representative (e.g., requests for the record to be left open) will result in a day-for-day delay for the decision date. The department shall provide the appellant and representative with written notice of the reason for the decision delay and the delayed decision date, if applicable.

12VAC30-121-200. Prehearing decisions.

A. If the Appeals Division determines that any of the conditions as described in this subsection exist, a hearing will not be held and the appeal process shall be terminated.

1. The appeal request was not filed within the time limit imposed by 12VAC30-121-195 or extended pursuant to 12VAC30-121-195 J, and

a. The appellant did not reply to the hearing officer's request for an explanation that met good cause criteria, or

b. The appellant did reply and the hearing officer had sufficient facts to determine that the reply did not meet good cause criteria pursuant to 12VAC30-121-195.

2. The individual who filed the appeal is not the appellant and has not submitted any authorization to represent the appellant under the provisions of 12VAC30-121-190 G.

3. The participating plan's internal appeals process was not exhausted prior to the enrollee's request for a state fair hearing.

4. The services denied or terminated were Medicare covered services. In that instance, the appeal request shall be handled by the Medicare external review entity.

5. The action being appealed was not taken by DMAS, its agent, or contractor, or the issue of the appeal is not related to the MMP's internal appeal decision.

6. Subsequent to the appeal request, the appellant's request for services was approved for the full amount, duration, and scope of the services requested.

7. The appellant or his representative failed to appear at the scheduled hearing, and

a. Did not reply to the hearing officer's request for an explanation that met good cause criteria, or

b. Did reply and the hearing officer had sufficient facts to determine that the reply did not meet good cause criteria pursuant to 12VAC30-121-195.

8. After a written notice of the telephonic hearing has been agreed to by the appellant and sent to the appellant and the appellant or his representative failed to respond to the hearing officer's request for a telephone number at which he could be reached for the telephonic hearing.

9. The appellant or his representative withdrew the appeal request.

10. The sole issue is a federal or state law requiring an automatic change adversely affecting some or all beneficiaries.

11. The hearing officer determined from the record, without conducting a hearing, that the participating plan's decision was clearly in error and that the case should be resolved in the appellant's favor. The hearing officer may issue a decision pursuant to 12VAC30-121-210 I.

B. If the hearing officer determined from the record, without conducting a hearing, that the case might be resolved in the appellant's favor if the participating plan obtains and develops additional information, documentation, or verification, the hearing officer may remand the case to the participating plan for action consistent with the hearing officer's written instructions pursuant to 12VAC30-121-210 I.

C. A letter shall be sent to the appellant or his representative that explains the determination made on his appeal.

D. The appellant shall have no opportunity to seek judicial review except in cases where the hearing officer receives and analyses a submission or response from the appellant or representative, or the hearing officer analyzes the merits of the agency's action.

12VAC30-121-210. Hearing process and final decision.

A. All hearings must be scheduled at a reasonable time, date, and place, and the appellant and his representative shall be notified in writing at least 15 days before the hearing.

1. The hearing location will be determined by the Appeals Division.

2. A hearing shall be rescheduled at the appellant's request no more than twice unless compelling reasons exist.

3. Rescheduling the hearing at the appellant's request will result in automatic waiver of the 90-day (or 75-day or 30-day) deadline for resolution of the appeal. The delay date for the decision will be calculated as set forth in 12VAC30-121-195 K.

B. The hearing shall be conducted by one or more hearing officers or other impartial individuals who have not been directly involved in the initial determination of the action in question or in the participating plan's appeal decision process. The hearing officer shall review the complete record for all

participating plan decisions that are properly appealed, conduct informal, fact-gathering hearings, evaluate evidence presented, research the issues, and render a written final decision.

C. Subject to the requirements of all applicable federal and state laws regarding privacy, confidentiality, disclosure, and personally identifiable information, the appeal record shall be made accessible to the appellant and representative at a convenient place and time before the date of the hearing, as well as during the hearing. The appellant and his representative may examine the content of the appellant's case file and all documents and records the department will rely on at the hearing except those records excluded by law.

D. Appellants who require the attendance of witnesses or the production of records, memoranda, papers, and other documents at the hearing may request in writing the issuance of a subpoena. The request must be received by the department at least 10 working days before the scheduled hearing. Such request shall (i) include the witness's or respondent's name, home and work addresses, county or city of work and residence, and (ii) identify the sheriff's office that will serve the subpoena.

E. The hearing officer shall conduct the hearing; decide on questions of evidence, procedure, and law; question witnesses; and assure that the hearing remains relevant to the issue or issues being appealed. The hearing officer shall control the conduct of the hearing and decide who may participate in or observe the hearing.

F. Hearings shall be conducted in an informal, nonadversarial manner. The appellant or his representative shall have the right to bring witnesses, establish all pertinent facts and circumstances; present an argument without undue interference, and question or refute the testimony or evidence, including the opportunity to confront and cross-examine agency representatives.

G. The rules of evidence shall not strictly apply. All relevant, nonrepetitive evidence may be admitted, but the probative weight of the evidence will be evaluated by the hearing officer.

H. The hearing officer may leave the hearing record open for a specified period of time after the hearing in order to receive additional evidence or argument from the appellant or his representative.

1. The hearing officer may order an independent medical assessment when the appeal involves medical issues, such as a diagnosis, an examining physician's report, or a medical review team's decision, and the hearing officer determines that it is necessary to have an assessment by someone other than the person or team who made the original decision (e.g., to obtain more detailed medical findings about the impairments, to obtain technical or specialized medical information, or to resolve conflicts or differences in medical findings or assessments in the existing evidence). A medical assessment ordered pursuant to this regulation shall be at the department's expense and shall become part of the record.

2. The hearing officer may receive evidence that was not presented by either party if the record indicates that such evidence exists, and the appellant or his representative requests to submit it or requests that the hearing officer secure it.

3. If the hearing officer receives additional evidence from an entity other than the appellant or his representative, the hearing officer shall send a copy of such evidence to the appellant and his representative, and give the appellant or his representative the opportunity to comment on such evidence in writing or to have the hearing reconvened to respond to such evidence.

4. Any additional evidence received will become a part of the hearing record, but the hearing officer must determine whether or not it will be used in making the decision.

I. After conducting the hearing, reviewing the record, and deciding questions of law, the hearing officer shall issue a written final decision that either sustains or reverses the participating plan's action or remands the case to the participating plan for further evaluation consistent with his written instructions. Some decisions may be a combination of these dispositions. The hearing officer's final decision shall be considered as the department's final administrative action pursuant to 42 CFR 431.244(f). The final decision shall include:

1. Identification of the issue or issues;

2. Relevant facts, to include a description of the procedural development of the case;

3. Conclusions of law, regulations, and policy that relate to the issue or issues;

4. Discussions, analysis of the accuracy of the participating plan's decision, conclusions, and hearing officer's decision;

5. Further action, if any, to be taken by the participating plan to implement the decision;

6. The deadline date by which further action must be taken; and

7. A cover letter informing the appellant and his representative of the hearing officer's decision. The letter must indicate that the hearing officer's decision is final, and that the final decision may be appealed directly to circuit court.

J. A copy of the hearing record shall be forwarded to the appellant and his representative with the final decision.

K. An appellant who disagrees with the hearing officer's final decision described in this section may seek judicial review pursuant to the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia) and Rules of the Supreme Court of Virginia, Part Two A. Written instructions for requesting judicial review must be provided to the

appellant or his representative with the hearing officer's decision, and upon request by the appellant or representative.

12VAC30-121-220. Division appeal records.

A. No person shall take from the division's custody any original record, paper, document, or exhibit that has been certified to the division except as the Appeals Division director or his designee authorizes, or as may be necessary to furnish or transmit copies for other official purposes.

B. Information in the appellant's record can be released only to the appellant, his authorized representative, the participating plan, other entities for official purposes, and other persons named in a release of information authorization signed by an appellant or his representative.

C. The fees to be charged and collected for any copy of division records will be in accordance with Virginia's Freedom of Information Act (§ 2.2-3700 et seq. of the Code of Virginia) or other controlling law.

D. When copies are requested from records in the division's custody, the required fee shall be waived if the copies are requested in connection with an enrollee's own appeal.

12VAC30-121-230. Provider appeals.

A. The Appeals Division maintains an appeal process for enrolled providers of Medicaid services who have rendered services and are requesting to challenge a participating plan's internal appeal of an adverse decision regarding payment. The participating plan's internal appeal process is a prerequisite to filing for an external appeal to the department's appeal process. The appeal process is available to (i) enrolled Medicaid service providers that have rendered services and have been denied payment in whole or part for Medicaid covered services and (ii) enrolled Medicaid service providers who have received a Notice of Program Reimbursement or overpayment demand from the department or its contractors.

B. Department provider appeals shall be conducted in accordance with the department's provider appeal regulations (12VAC30-20-500 et seq.), § 32.1-325 et seq. of the Code of Virginia, and the Virginia Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia).

C. The department's external appeal decision shall be binding upon the participating plan or plans and not subject to further appeal by the participating plan or plans.

D. If the provider is successful in its appeal, then the MMP shall reimburse it for the appealed issue.

12VAC30-121-240. (Reserved.)

12VAC30-121-250. Marketing and enrollee communication standards for participating plans.

A. Participating plans shall be subject to rules governing their marketing and enrollee communications as specified under §§ 1851(h) and 1932(d)(2) of the Social Security Act; 42 CFR 422.111, 42 CFR 422.2260 et. seq., 42 CFR 423.120(b) and (c), 42 CFR 423.128, and 42 CFR 423.2260 et. seq.; and the Medicare Marketing Guidelines (Chapter 2 of the Medicare Managed Care Manual and Chapter 3 of the Prescription Drug Benefit Manual).

1. Participating plans shall not be allowed to market directly to potential enrollees. Instead, plans may participate in group marketing events, provide general audience materials (such as general circulation brochures, and media and billboard advertisements), and provide responses to individual-initiated requests for enrollment.

2. Participating plans shall receive prior approval of all marketing and enrollee communications materials except those that are exempt pursuant to 42 CFR 422.2262(b) and 423.2262(b).

3. Plans shall not begin marketing activity earlier than 90 days prior to the effective date of enrollment for the contract year.

B. At a minimum, participating plans will provide current and prospective enrollees the following materials, subject to the rules regarding content and timing of enrollee receipt as applicable under § 1851(h) of the Social Security Act: 42 CFR 422.111, 42 CFR 422.2260 et. seq., 42 CFR 423.120(b) and (c), 42 CFR 423.128, 42 CFR 423.2260 et. seq., 42 CFR 438.10, 42 CFR 438.104, the three way contract, and the Medicare Marketing Guidelines.

C. Notification of formulary changes. The requirement at 42 CFR 423.120(b)(5) that participating plans provide at least 60 days advance notice regarding Medicare Part D formulary changes also applies to participating plans for outpatient prescription or over-the-counter drugs or products covered under Medicaid or as additional benefits.

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

FORMS (12VAC30-121)

Agency or Consumer Direction Provider Plan of Care, DMAS-97A/B (rev. 3/10)

DOCUMENTS INCORPORATED BY REFERENCE (12VAC30-121)

Memorandum of Understanding (MOU) Between the Centers for Medicare & Medicaid Services (CMS) and the Commonwealth of Virginia Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees (Commonwealth Coordinated Care), signed May 21, 2013

Medical Marketing Guidelines, Centers for Medicare & Medicaid Services, revised June 17, 2014

VA.R. Doc. No. R15-3786; Filed December 10, 2014, 11:11 a.m.

Fast-Track Regulation

Titles of Regulations: **12VAC30-50. Amount, Duration, and Scope of Medical and Remedial Care Services (adding 12VAC30-50-415).**

12VAC30-80. Methods and Standards for Establishing Payment Rates; Other Types of Care (amending 12VAC30-80-110).

12VAC30-120. Waivered Services (amending 12VAC30-120-380).

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

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: January 28, 2015.

Effective Date: February 13, 2015.

Agency Contact: Molly Carpenter, Policy Analyst, Department of Medical Assistance Services, Division of Maternal and Child Health, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 786-1493, FAX (804) 786-1680, or email molly.carpenter@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 Plan for Medical Assistance. Section 32.1-324 of the Code of Virginia authorizes the Director of the Department of Medical Assistance Services (DMAS) to administer and amend the Plan for Medical Assistance according to the board's requirements. The Medicaid authority as established by § 1902(a) of the Social Security Act (42 USC § 1396a) provides governing authority for payments for services.

Part C of the Individuals with Disabilities Education Act (20 USC § 1431 et seq.) was designed to assist each state to maintain and implement a statewide, comprehensive, coordinated, multidisciplinary, interagency system to provide early intervention services for infants and toddlers with disabilities and their families. Pursuant to Chapter 53 (§ 2.2-5300 et.seq.) of Title 2.2 of the Code of Virginia, the Department of Behavioral Health and Developmental Services (DBHDS) was appointed state lead agency for Part C services in the Commonwealth (§ 2.2-5304 of the Code of Virginia and 12VAC35-220-10). The Code of Virginia also designates DMAS as a participating agency with a duty to identify and maximize coordination of public and private resources for early intervention services.

Under the authority of Item 297 UUUU of Chapter 890 of the 2011 Acts of the Assembly, DMAS promulgated an emergency regulation for this issue:

Purpose: This regulatory action creates a new model for Medicaid coverage of case management services for children younger than three years of age who receive services under Chapter 53 (§ 2.2-5300 et seq.) of Title 2.2 of the Code of Virginia in accordance with Part C of the Individuals with Disabilities Education Act (20 USC § 1431 et seq.). These children have (i) a 25% developmental delay in one or more areas of development, (ii) atypical development, or (iii) a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay.

The planned regulatory action is one component of this administration's initiative to revise the system of financing for Part C early intervention services in Virginia to make more efficient use of federal and state funds. Obtaining Medicaid reimbursement for required case management services ensures that the Commonwealth will draw down the maximum available federal Medicaid match for those Part C services currently paid with state-only funds. DBHDS is proposing new regulations for certification of early intervention case managers in tandem with this regulatory action. DMAS consulted with DBHDS and other stakeholders in developing these regulations.

The regulation continues to protect the health and welfare of this population.

Rationale for Using Fast-Track Process: This regulatory action represents a shifting of funding from 100% general fund (GF) to 50% GF and 50% nongeneral fund (NGF). This service was already being provided by the Commonwealth's early intervention system. By having DMAS assume payment responsibility for children who are eligible for Title XIX (Medicaid), it frees up half of the GF dollars for use for children who are not eligible for these two programs, thereby doubling the numbers of children who can be served with state funds. DMAS met with the affected provider community during the development of the current emergency regulations, and they were very supportive of this concept and have received it positively since implementation via the emergency regulations. Consequently, DMAS is not expecting any objections to the fast-track process.

Substance: Currently, there is no defined Medicaid case management service that meets the needs of infants and toddlers with developmental disabilities who are being served by the Part C early intervention program. Community services boards (CSBs) are billing Medicaid for targeted case management services for some of these children under provisions designed for individuals receiving services for mental health or intellectual disabilities (12VAC30-50-420, 12VAC30-50-430, 12VAC30-50-440, and 12VAC30-50-450). Although many children receiving early intervention services may technically fall within the definition of these other target groups, these case management models were not designed to be used for early intervention participants. These models include requirements that are not applicable to the early intervention population, and service providers are limited to CSBs.

Prior to promulgation of emergency regulations, CSBs billed Medicaid for targeted case management under the mental health or intellectual disabilities services models for approximately 35% of the children who are covered by

Medicaid and enrolled in the Part C early intervention program, reimbursed at an average rate of $326.50 per month.

These regulations define a new approach to payment for case management services under Medicaid that supports the Part C early intervention model. The new early intervention case management service will meet federal Part C requirements for care coordination as well as federal Medicaid requirements for case management reimbursement. Case managers will be certified by DBHDS to ensure that they have the expertise to effectively address the needs of children with developmental delays and their families under the federal Part C program. In addition to coordinating specialized services needed to ameliorate the child's developmental delay, this new case management model will facilitate coordination with the child's primary care provider and support quality preventive services such as well child care, immunizations, and lead testing, which are covered under the early and periodic screening, diagnosis and treatment (EPSDT) program for all children enrolled in Medicaid.

Some infants who receive services through the Part C early intervention program may also receive targeted case management services for high-risk pregnant women and children (12VAC30-50-410). These services are designed to improve birth outcomes and reduce infant mortality by increasing access to care and promoting continuity of care for women with a high-risk pregnancy through the prenatal period and infancy. Providers of this targeted case management service are limited to registered nurses and trained social workers with experience working with pregnant women. Early intervention case management providers will be required to coordinate services with these case managers to avoid duplication of services.

The early intervention targeted case management service will reimburse for coordination services that are federally required by the Part C early intervention program to assist children and their families. All local lead agencies under contract with DBHDS or their designees will be eligible to receive Medicaid reimbursement for targeted case management services. All private and governmental fee-for-service providers will be paid according to the same methodology. Early intervention targeted case management providers will be reimbursed by DMAS outside of the Medallion II managed care contracts. This is consistent with Medicaid reimbursement for services provided by early intervention practitioners under EPSDT as well as for most targeted care management.

DMAS anticipates implementing this regulatory action without increased cost to the Commonwealth or localities. The General Assembly established a rate of $132 per month for this service effective July 1, 2012. The projected savings associated with the elimination of payment for case management under the mental health and intellectual disabilities models for children served by the Part C early intervention program will offset the new costs incurred under the new model for the entire Part C population covered by Medicaid. The agency fee scale will define rates that are budget neutral with the amount of money that is currently being spent on early intervention participants who previously utilized Medicaid case management services designed for other target groups.

Issues: The fast-track regulatory action is needed to support early intervention services as provided under Chapter 53 (§ 2.2-5300 et seq.) of Title 2.2 of the Code of Virginia and in accordance with Part C of the Individuals with Disabilities Education Act (20 USC § 1431 et seq.), which are designed to address developmental problems in young children. These services are provided to children from birth to three years of age who have (i) a 25% developmental delay in one or more areas of development, (ii) atypical development, or (iii) a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay. Research suggests that these problems are most effectively addressed by a multidisciplinary approach working in partnership with the child's family.

Case management is an integral component of the Part C early intervention program. Case management services are designed to assist individuals in gaining access to needed medical, social, educational, and other services. Case management includes comprehensive assessment and periodic reassessment to determine the need for medical, educational, social, or other services; development and periodic revision of an individualized family service plan (IFSP) to address identified needs; referral and assistance to help the family obtain the needed services; and monitoring and follow-up to ensure that the IFSP is implemented and addresses the identified needs.

DBHDS receives Virginia's federal Part C allotment and administers the statewide early intervention program through contracts with local lead agencies. The majority of local lead agencies are under the auspices of community services boards, along with several universities, public health districts, local governments, and local education agencies.

Qualified providers are needed for case management services to effectively address the special health needs of the Part C population. An advantage for the public and the Commonwealth is that this new early intervention case management service is designed to ensure that providers have the specific expertise to effectively address developmental problems in young children and their families as provided for in Part C.

There are no disadvantages to the public or the Commonwealth associated with the suggested regulatory action.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. Pursuant to Chapter 890, Item 297 UUUU of the 2011 Acts of the Assembly, the proposed regulations create a new model

for Medicaid coverage of case management services for certain children.

Result of Analysis. The benefits likely exceed the costs for one or more proposed changes. There is insufficient data to accurately compare the magnitude of the benefits versus the costs for other changes.

Estimated Economic Impact. Pursuant to Chapter 890, Item 297 UUUU of the 2011 Acts of the Assembly, the proposed regulations create a new model for Medicaid coverage of case management services for children younger than three years of age who receive services in accordance with Part C of the federal Individuals with Disabilities Education Act. These children have (i) a 25% developmental delay in one or more areas of development, (ii) atypical development, or (iii) a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay. The proposed changes have already been implemented under emergency regulations that became effective in October 2011.

Prior to the emergency regulations, there was no defined Medicaid case management service that met the needs of infants and toddlers with developmental disabilities who are being served by the Part C early intervention program. Community services boards (CSBs) were billing Medicaid for targeted case management services for some of these children under provisions designed for individuals receiving services for mental health or intellectual disabilities. Although many children receiving early intervention services may technically fall within the definition of these other target groups, these case management models were not designed to be used for early intervention participants. These models included requirements that are not applicable to the early intervention population, and service providers are limited to CSBs.

The proposed regulations define a new approach to payment for case management services under Medicaid that supports the Part C early intervention model. The new Early Intervention Case Management service meets federal Part C requirements for care coordination as well as federal Medicaid requirements for case management reimbursement. Case managers are certified by the Department of Behavioral Health and Developmental Services (DBHDS) to ensure that they have the expertise to effectively address the needs of children with developmental delays and their families under the federal Part C program.

In addition to coordinating specialized services needed to ameliorate the child's developmental delay, this new case management model facilitates coordination with the child's primary care provider and supports quality preventive services such as well child care, immunizations, and lead testing, which are covered under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program for all children enrolled in Medicaid. Some infants who receive services through the Part C early intervention program may also receive targeted case management services for high risk pregnant women and children. These services are designed to improve birth outcomes and reduce infant mortality by increasing access to care and promoting continuity of care for women with a high risk pregnancy through the prenatal period and infancy.

The proposed regulations revise the system of financing for Part C early intervention services in Virginia to make more efficient use of federal and state funds. Obtaining Medicaid reimbursement for required case management services ensures that the Commonwealth draws down available federal Medicaid match for those Part C services currently paid with state-only funds. With the new system, DBHDS no longer pays for services from state-only funds for the children who are now served through Medicaid. However, the magnitude of savings in state-only funds is not available at this time.

In addition, the reimbursement rate for services provided under the new model decreased. The average reimbursement rate under the old model was $326.50 per child per month. Under the new model, the reimbursement rate is currently $132 per child per month. Thus, the proposed changes make it possible to serve a larger population with the same amount of funds. For example, one year before the emergency regulations were implemented, $4.9 million (state and federal funds combined) were spent to serve 2,724 children through Medicaid. The following year the total expenditures through Medicaid went down to $4.3 million, and 6,952 children were served. In short, the proposed new financing model not only eliminated the state-only funds expended by DBHDS, but also reduced Medicaid expenditures while serving more children.

Businesses and Entities Affected. According to DMAS, there were 6,952 children served by this program within one year of the implementation of the emergency regulations. There are approximately 70 businesses providing early intervention services, of which 53 are enrolled with Medicaid.

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

Projected Impact on Employment. The proposed new financing of early intervention services eliminates state-only expenditures for early intervention services now paid through Medicaid. These funds now may be spent on other goods and services having a positive impact on employment in other sectors. On the other hand, reduction in reimbursement rates may discourage some of the early intervention providers from providing their services and have a negative impact on employment.

Effects on the Use and Value of Private Property. Under the proposed regulations, some businesses in other sectors may see an increase in their revenues that would have a positive impact on their asset values. On the other hand, early intervention providers would see a decline in their revenues due to reduction in the reimbursement rate that would negatively affect their profitability and asset values.

Small Businesses: Costs and Other Effects. Most if not all of the 70 businesses providing early intervention services in the

Commonwealth are small businesses. Thus, the economic effects on providers discussed above apply to them.

Small Businesses: Alternative Method that Minimizes Adverse Impact. There is no known alternative that minimizes the adverse impact on small businesses while accomplishing the same goals.

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

Legal Mandate. The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007.04 of the Administrative Process Act and Executive Order Number 14 (10). Section 2.2-4007.04 requires that such economic impact analyses include, but need not be limited to, a determination of the public benefit, the projected number of businesses or other entities to whom the regulation would apply, the identity of any localities and types of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or entities to implement or comply with the regulation, and the impact on the use and value of private property. Further, if the proposed regulation has an adverse effect on small businesses, § 2.2-4007.04 requires that such economic impact analyses include (i) an identification and estimate of the number of small businesses subject to the regulation; (ii) the projected reporting, recordkeeping, and other administrative costs required for small businesses to comply with the regulation, including the type of professional skills necessary for preparing required reports and other documents; (iii) a statement of the probable effect of the regulation on affected small businesses; and (iv) a description of any less intrusive or less costly alternative methods of achieving the purpose of the regulation. The analysis presented above represents DPB's best estimate of these economic impacts.

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

Summary:

The regulations create a new model for Medicaid coverage of early intervention case management services for children younger than three years of age who receive services under Chapter 53 (§ 2.2-5300 et seq.) of Title 2.2 of the Code of Virginia in accordance with Part C of the Individuals with Disabilities Education Act (20 USC § 1431 et seq.). The new early intervention targeted case management service meets federal requirements under Part C for care coordination as well as federal Medicaid requirements for targeted case management reimbursement. The regulations provide that case managers will be certified by the Department of Behavioral Health and Developmental Services to ensure that case managers have the expertise to effectively address the needs of children with developmental delays and their families under Part C. In addition to coordinating specialized services needed to ameliorate the child's developmental delay, this model will facilitate coordination with the child's primary care provider and support quality preventive services such as well child care, immunizations, and lead testing, which are covered under the early and periodic screening, diagnosis and treatment program for all children enrolled in Medicaid.

12VAC30-50-415. Case management for individuals receiving early intervention (Part C) services.

A. Target group for early intervention case management. Medicaid eligible children from birth up to three years of age who have (i) a 25% developmental delay in one or more areas of development, (ii) atypical development, or (iii) a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay who participate in the early intervention services system described in Chapter 53 (§ 2.2-5300 et seq.) of Title 2.2 of the Code of Virginia are the target group.

B. Services are provided throughout the Commonwealth.

C. Services are not comparable in amount, duration, and scope. The authority of § 1915(g)(1) of the Social Security Act (the Act) is invoked to provide services without regard to the requirements of § 1902(a)(10)(B) of the Act.

D. Definition of services. Early intervention case management services are services furnished to assist individuals eligible under the State Plan who reside in a community setting in gaining access to medical, social, educational, and other services. Early intervention case management includes the following assistance:

1. Comprehensive assessment and at least annual reassessment of individual needs to determine the need for any medical, educational, social, or other services, including EPSDT services.

2. Development and at least annual revision of an individualized family service plan (IFSP) as defined in coverage of early intervention services under Part C of Individuals with Disabilities Education Act (IDEA) (12VAC30-50-131) based on the information collected through the assessment. A face-to-face contact with the child's family is required for the initial development and revision of the IFSP. The case manager shall be responsible for determining if the family's particular situation warrants additional face-to-face visits.

3. Referral and related activities to help the eligible individual obtain needed services, including activities that help link the individual with medical, social, and educational providers or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the IFSP.

4. Monitoring and follow-up activities, including activities and contacts that are necessary to ensure that the IFSP is

effectively implemented and adequately addresses the needs of the eligible individual. At a minimum one telephone, email, or face-to-face contact shall be made with the child's family every three calendar months, or attempts of such contacts. This contact or attempted contact shall be documented. The case manager shall be responsible for determining if the family's particular situation warrants additional family contacts.

5. Early intervention case management includes contacts with family members, service providers, and other noneligible individuals and entities who have direct knowledge of the eligible individual's needs and care.

E. Qualifications of providers. Individual providers of early intervention case management must be certified as early intervention case managers by the Department of Behavioral Health and Developmental Services.

F. Freedom of choice. The Commonwealth assures that the provision of case management services will not restrict an eligible individual's freedom of choice of providers.

1. Eligible recipients shall have free choice of the providers of early intervention case management services within the specified geographic area identified in this plan.

2. Eligible recipients shall have free choice of the providers of other medical care under the plan.

3. Providers of early intervention case management shall be limited to entities designated by the local lead agencies under contract with the Department of Behavioral Health and Developmental Services pursuant to § 2.2-5304.1 of the Code of Virginia.

G. Access to services. The Commonwealth assures the following:

1. Case management services shall be provided in a manner consistent with the best interest of recipients and shall not be used to restrict an individual's access to other Medicaid services.

2. Individuals shall not be compelled to receive case management services. The receipt of other Medicaid services shall not be a condition for the receipt of case management services, and the receipt of case management services shall not be a condition for receipt of other Medicaid services.

3. Providers of case management services do not exercise DMAS authority to authorize or deny the provision of other Medicaid services.

H. Payment for early intervention case management services shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

I. Case records. Case management services shall be documented and maintained in individual case records in accordance with 42 CFR 441.18(a)(7). Case records shall include:

1. The name of the individual;

2. The dates of the case management services;

3. The name of the provider agency and the person providing the case management services;

4. The nature, content, and units of the case management services received and whether the goals specified in the care plan have been achieved;

5. Whether the individual has declined services in the care plan;

6. The need for, and occurrences of, coordination with other case managers;

7. A timeline for obtaining needed services; and

8. A timeline for reevaluation of the plan.

J. Limitations.

1. Early intervention case management shall not include the following:

a. Activities not consistent with the definition of case management services in 42 CFR 440.169.

b. The direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred.

c. Activities integral to the administration of foster care programs.

d. Activities for which third parties are liable to pay, except for case management that is included in an IFSP consistent with § 1903(c) of the Social Security Act.

2. Providers shall not be reimbursed for case management services provided for these groups when these children also fall within the target group for early intervention case management as set out in this subdivision:

a. Seriously mentally ill adults and emotionally disturbed children (12VAC30-50-420);

b. Youth at risk of serious emotional disturbance (12VAC30-50-430);

c. Individuals with intellectual disability (12VAC30-50-440); or

d. Individuals with intellectual disability and related conditions who are participants in the home and community-based care waivers for persons with intellectual disability and related conditions (12VAC30-50-450).

3. Case management shall be reimbursed only when all of the following conditions are met:

a. A least one documented case management service is furnished during the month; and

b. The provider is certified by the Department of Behavioral Health and Developmental Services and enrolled with DMAS as an early intervention case management provider.

12VAC30-80-110. Fee-for-service: case management.

A. Targeted case management for high-risk pregnant women and infants up to ~~age~~ two years of age, for community mental health and ~~mental retardation~~ intellectual disability services, and for individuals who have applied for or are participating in the Individual and Family Developmental Disability Support Waiver program (IFDDS Waiver) shall be reimbursed at the lowest of: state agency fee schedule, actual charge, or Medicare (Title XVIII) allowances.

B. Targeted case management for early intervention (Part C) children.

1. Targeted case management for children from birth to three years of age who have developmental delay and who are in need of early intervention is reimbursed at the lower of the state agency fee schedule or actual charge (charge to the general public). The unit of service is monthly. All private and governmental fee-for-service providers are reimbursed according to the same methodology. The agency's rates are effective for services on or after October 11, 2011. Rates are published on the agency's website at www.dmas.virginia.gov.

2. Case management shall not be billed when it is an integral part of another Medicaid service including, but not limited to, intensive community treatment services and intensive in-home services for children and adolescents.

3. Case management defined for another target group shall not be billed concurrently with this case management service except for case management services for high risk infants provided under 12VAC30-50-410. Providers of early intervention case management shall coordinate services with providers of case management services for high risk infants, pursuant to 12VAC30-50-410, to ensure that services are not duplicated.

4. Each entity receiving payment for services as defined in 12VAC30-50-415 shall be required to furnish the following to DMAS, upon request:

a. Data, by practitioner, on the utilization by Medicaid beneficiaries of the services included in the unit rate; and

b. Cost information by practitioner.

5. Future rate updates will be based on information obtained from the providers. DMAS monitors the provision of targeted case management through post-payment review (PPR). PPRs ensure that paid services were rendered appropriately, in accordance with state and federal policies and program requirements, provided in a timely manner, and paid correctly.

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

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

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

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

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

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

D. Documentation requirements.

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

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

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

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

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

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

I. In accordance with 42 CFR 447.50 through 42 CFR 447.60, MCOs shall not impose any cost sharing obligations on enrollees except as set forth in 12VAC30-20-150 and 12VAC30-20-160.

J. An MCO may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee 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.

VA.R. Doc. No. R13-2955; Filed December 10, 2014, 11:15 a.m.

Fast-Track Regulation

Titles of Regulations: **12VAC30-70. Methods and Standards for Establishing Payment Rates - Inpatient Hospital Services (amending 12VAC30-70-221, 12VAC30-70-281, 12VAC30-70-291).**

12VAC30-80. Methods and Standards for Establishing Payment Rates; other Types of Care (amending 12VAC30-80-20, 12VAC30-80-30; adding 12VAC30-80-300).

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

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: January 28, 2015.

Effective Date: February 13, 2015.

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

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

Based on authority under Item 307 B 4 of the 2012 Appropriation Act (Chapter 3 of the 2012 Acts of Assembly, Special Session I) and Item 301 B 4 of the 2014 Appropriation Act (Chapter 3 of the 2014 Acts of Assembly, Special Session I) this action revises the average commercial rate for the state academic health centers and changes general medical education (GME) and indirect medical education (IME) reimbursement for state academic health centers.

Purpose: The purpose of this action is to increase reimbursement to (i) physicians affiliated with Type One hospitals and state-funded medical schools, (ii) hospital and nursing home partners with Type One hospitals, and (iii) Type One hospitals by modifying or establishing supplemental payments. This action also changes reimbursement for GME to cover costs for Type One hospitals, changes the formula for IME by changing adjustment factor applied to the operating rate to 1.0, and case-mix adjusts the formula for reimbursement for health maintenance organization (HMO) discharges for Type One hospitals.

This action has no direct impact on the health, safety, or welfare of either Medicaid individuals or the Commonwealth's citizens at large.

Rationale for Using Fast-Track Process: This regulatory change is being promulgated through the fast-track rulemaking process because it is expected to be noncontroversial. The Department of Medical Assistance Services (DMAS) consulted with the Virginia Hospital and Healthcare Association (VHHA) and the affected providers. VHHA indicated that it would not object to increasing reimbursement to Type One hospitals. The affected providers are satisfied with supplemental payment calculation and methodology; therefore, no opposition is expected as a result of this fast-track regulatory action.

Substance:

A. Supplemental payments for physicians. The current Virginia Administrative Code (VAC) includes physician supplemental payments for physician practice plans affiliated with Type One hospitals (state academic health systems).

These payments are calculated as the difference between the maximum payment allowable and regular payments. The Centers for Medicare and Medicaid Services (CMS) has determined that the maximum allowable is the average commercial rate (ACR). When first established in 2002, DMAS documented that the average commercial rate was 143% of Medicare based on information furnished by the state academic health systems. Based on authority under Item 301 B 4 of Chapter 3 of the 2014 Acts of Assembly, Special Session I, the purpose of this action is to revise the maximum to 181% of Medicare based on updated information on the average commercial rate furnished by the state academic health systems.

DMAS estimates that this action will increase physician supplemental payments for practice plans affiliated with Type One hospitals by $3.2 million (general funds) annually and will replace funding that is no longer available from disproportionate share hospitals (DSH).

The regulation also codifies the methodology for calculating the ACR rate as a percentage of Medicare used in calculating supplemental payments for physicians.

B. Supplemental payments for outpatient hospital services at Type One hospitals. Federal regulations establish upper payment limits (UPLs) for outpatient hospital services. There are separate UPLs for state, other government, and private hospitals. UPLs are calculated on an aggregate basis. Under the current VAC, outpatient regular payments for Type One hospitals are below the UPL. This amendment would create supplemental payments for Type One hospitals. Type One hospitals are the state teaching hospitals. Outpatient reimbursement for Type One hospitals is approximately 92% of cost. The intent of this action is to provide increased payments for outpatient hospital services for state teaching hospitals.

This action is estimated to generate an increase in annual reimbursement of $1.6 million in total funds ($800,000 general funds) and will replace funding that is no longer available from DSH.

C. IME and GME reimbursement changes for Type One hospitals. Based on authority under Item 301 B 4 of Chapter 3 of the 2014 Acts of Assembly, Special Session I, the hospital inpatient reimbursement for Type One hospitals is being amended to change reimbursement for GME to cover GME costs for Type One hospitals, to case mix adjust the formula for IME reimbursement for HMO discharges for Type One hospitals and to increase the adjustment factor for Type One hospitals to 1.0 for use in calculating the IME reimbursement for HMO discharges. The intent of these changes is to fully reimburse Type One hospitals for the GME and IME costs associated with managed care services.

This action is estimated to increase annual GME and IME reimbursement by $84.4 million in total funds ($42.2 million general funds) and will replace funding that is no longer available from DSH.

Issues: The actions identified in the regulation package do not impact the public. These actions increase reimbursement to teaching hospitals to support access to care for the medically needy. This action is expected to be advantageous to the state because it increases reimbursement to the state teaching hospitals for which DMAS claims 50% federal matching funds. Increased financial support to the state teaching hospitals by Medicaid reduces the hospitals' need for General Fund dollars.

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 modify or establish supplemental payments for 1) physicians affiliated with Type One hospitals, and 2) Type One hospitals.[1] The Board also proposes to modify indirect medical education (IME) and graduate medical education (GME) reimbursement for Type One hospitals.

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

Estimated Economic Impact. All proposed changes are already in the State Budget and are in effect in practice. The "Supplemental Payments for Physicians" and "IME and GME Reimbursement Changes for Type One Hospitals" described below are directly specified in the budget; while "Supplemental Payments for Outpatient Hospital Services at Type One Hospitals," also described below, is a subcategory of an item specified in the budget. The proposed changes help ensure that the Commonwealth maximizes federal dollars received and do not increase current state expenditure.

Item 307 B 4 of the 2012 Appropriation Act allows the Department of Medical Assistance Services (DMAS) to increase Medicaid payments for Type One hospitals and physicians to compensate for limits on disproportionate share hospital (DSH) payments and to change reimbursement for GME to cover costs for Type One hospitals. The budget language also directs DMAS to case mix adjust the formula for IME for HMO discharges for Type One hospitals and to increase the adjustment factor for Type One hospitals to 1.0. Currently, the only Type One hospitals in the state are the University of Virginia Health System and the Virginia Commonwealth University Health System. The effect of these changes is that it would increase reimbursement for these groups; however this does not represent an additional cost for the state.

Supplemental Payments for Physicians:

The Centers for Medicare and Medicaid Services determined that the maximum payment allowable is the average commercial rate (ACR). Currently, these payments are calculated as the difference between the maximum payment allowable and regular payments. Since this program was first established in 2002, the ACR was 143 percent of Medicare. The 2012 Appropriation Act increased the maximum ACR to 181 percent.

DMAS estimates that this action increases physician supplemental payments for practice plans affiliated with Type One hospitals by $3.2 million (General Fund) annually and replaces funding that is no longer available from Disproportionate Share Hospitals (DSH).

IME and GME Reimbursement Changes for Type One Hospitals:

The hospital inpatient reimbursement for Type One hospitals is amended to cover GME costs for Type One hospitals, to case mix adjust the formula for IME reimbursement for HMO discharges for Type One hospitals, and to increase the adjustment factor for Type One hospitals from .6709 to 1.0 for use in calculating the IME reimbursement for HMO discharges. These changes are designed to incorporate the directive in the 2012 Appropriation Act to fully reimburse Type One hospitals for the GME and IME costs associated with managed care services.

This action increases annual GME and IME reimbursement by approximately $84.4 million in total funds ($42.2 million General Fund) and will replace funding that is no longer available from DSH.[2]

Supplemental Payments for Outpatient Hospital Services:

Federal regulations establish Upper Payment Limits (UPLs) for outpatient hospital services; these UPLS vary by classification as state, other government, or private hospitals and are calculated on an aggregate basis. Currently in regulation outpatient regular payments for Type One hospitals are below the UPL, at approximately 92 percent of the cost. Regulatory language is changed to provide increased payments for outpatient hospital services to attain the 100 percent UPL for the Type One hospitals.

This action is estimated to generate an increase in annual reimbursement of $1.6 million in total funds ($800,000 General Fund) and replaces funding that is no longer available from DSH.[3]

Businesses and Entities Affected. The proposed amendments particularly affect the two Type One hospitals in the Commonwealth and their approximate 1,481 affiliated physicians.[4] Type One hospitals are those hospitals that were state-owned teaching hospitals on January 1, 1996.[5] The proposed amendments also affect physicians affiliated with Type One hospitals and their practices.

Localities Particularly Affected. The two Type One hospitals in Virginia are located in Charlottesville and Richmond.

Projected Impact on Employment. The increased funding for the two Type One hospitals may permit these entities to increase employment.

Effects on the Use and Value of Private Property. The increased physician supplemental payments for practice plans affiliated with Type One hospitals positively affect the value of practices of physicians affiliated with Type One hospitals.

Small Businesses: Costs and Other Effects. The proposed amendments particularly affect the two Type One hospitals in the Commonwealth. Neither of the two Type One hospitals are small businesses. Physician practices would qualify as small businesses. Physician practices that have physicians affiliated with Type One hospitals receive greater revenue under the amendments.

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

Real Estate Development Costs. The proposed amendments are unlikely to significantly affect real estate development costs.

Legal Mandate.

General: The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007.04 of the Code of Virginia and Executive Order Number 17 (2014). Section 2.2-4007.04 requires that such economic impact analyses determine the public benefits and costs of the proposed amendments. Further the report should include but not be limited to:

- the projected number of businesses or other entities to whom the proposed regulatory action would apply,
- the identity of any localities and types of businesses or other entities particularly affected,
- the projected number of persons and employment positions to be affected,
- the projected costs to affected businesses or entities to implement or comply with the regulation, and
- the impact on the use and value of private property.

Small Businesses: If the proposed regulatory action will have an adverse effect on small businesses, § 2.2-4007.04 requires that such economic impact analyses include:

- an identification and estimate of the number of small businesses subject to the proposed regulation,
- the projected reporting, recordkeeping, and other administrative costs required for small businesses to comply with the proposed regulation, including the type of professional skills necessary for preparing required reports and other documents,
- a statement of the probable effect of the proposed regulation on affected small businesses, and
- a description of any less intrusive or less costly alternative methods of achieving the purpose of the proposed regulation.

Additionally, pursuant to § 2.2-4007.1, if there is a finding that a proposed regulation may have an adverse impact on small business, the Joint Commission on Administrative Rules (JCAR) is notified at the time the proposed regulation is submitted to the Virginia Register of Regulations for publication. This analysis shall represent DPB's best estimate for the purposes of public review and comment on the proposed regulation.

[1] "Type One" hospitals means those hospitals that were state-owned teaching hospitals on January 1, 1996. (12VAC30-70-221)

[2] Dollar estimates provided by Department of Medical Assistance Services

[3] Ibid

[4] Data source: Department of Medical Assistance Services

[5] Definition source: 12VAC30-70-221

Agency's Response to Economic Impact Analysis: The agency has reviewed the economic impact analysis prepared by the Department of Planning and Budget regarding the regulations concerning supplemental payments for institutional and noninstitutional providers. The agency raises no issues with this analysis.

Summary:

The amendments (i) modify or establish supplemental payments for (a) outpatient hospital services at Type One hospitals and (b) physicians affiliated with Type One hospitals and (ii) modify indirect medical education and graduate medical education reimbursement for Type One hospitals.

Article 2

Prospective (DRG-Based) Payment Methodology

12VAC30-70-221. General.

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

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

1. As stipulated in 12VAC30-70-231, operating payments for DRG cases that are not transfer cases shall be determined on the basis of a hospital specific operating rate per case times relative weight of the DRG to which the case is assigned.

2. As stipulated in 12VAC30-70-241, operating payments for per diem cases shall be determined on the basis of a hospital specific operating rate per day times the covered days for the case with the exception of payments for per diem cases in freestanding psychiatric facilities. Payments for per diem cases in freestanding psychiatric facilities licensed as hospitals shall be determined on the basis of a hospital specific rate per day that represents an all-inclusive payment for operating and capital costs.

3. As stipulated in 12VAC30-70-251, operating payments for transfer cases shall be determined as follows: (i) the transferring hospital shall receive an operating per diem payment, not to exceed the DRG operating payment that would have otherwise been made and (ii) the final discharging hospital shall receive the full DRG operating payment.

4. As stipulated in 12VAC30-70-261, additional operating payments shall be made for outlier cases. These additional payments shall be added to the operating payments determined in subdivisions 1 and 3 of this subsection.

5. As stipulated in 12VAC30-70-271, payments for capital costs shall be made on an allowable cost basis.

6. As stipulated in 12VAC30-70-281, payments for direct medical education costs of nursing schools and paramedical programs shall be made on an allowable cost basis. ~~Payment~~ For Type Two hospitals, payment for direct graduate medical education (GME) costs for interns and residents shall be made quarterly on a prospective basis, subject to cost settlement based on the number of full time equivalent (FTE) interns and residents as reported on the cost report. Effective April 1, 2012, payment for direct GME for interns and residents for Type One hospitals shall be 100% of allowable costs.

7. As stipulated in 12VAC30-70-291, payments for indirect medical education costs shall be made quarterly on a prospective basis.

8. As stipulated in 12VAC30-70-301, payments to hospitals that qualify as disproportionate share hospitals shall be made quarterly on a prospective basis.

C. The terms used in this article shall be defined as provided in this subsection:

"Base year" means the state fiscal year for which data is used to establish the DRG relative weights, the hospital case-mix indices, the base year standardized operating costs per case, and the base year standardized operating costs per day. The base year will change when the DRG payment system is rebased and recalibrated. In subsequent rebasings, the Commonwealth shall notify affected providers of the base year to be used in this calculation.

"Base year standardized costs per case" means the statewide average hospital costs per discharge for DRG cases in the base year. The standardization process removes the effects of case-mix and regional variations in wages from the claims data and places all hospitals on a comparable basis.

"Base year standardized costs per day" means the statewide average hospital costs per day for per diem cases in the base year. The standardization process removes the effects of regional variations in wages from the claims data and places all hospitals on a comparable basis. Base year standardized costs per day were calculated separately, but using the same calculation methodology, for the different types of per diem cases identified in this subsection under the definition of "per diem cases."

"Cost" means allowable cost as defined in Supplement 3 (12VAC30-70-10 through 12VAC30-70-130) and by Medicare principles of reimbursement.

"Disproportionate share hospital" means a hospital that meets the following criteria:

1. A Medicaid utilization rate in excess of 14%, or a low-income patient utilization rate exceeding 25% (as defined in the Omnibus Budget Reconciliation Act of 1987 and as amended by the Medicare Catastrophic Coverage Act of 1988); and

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

3. Subdivision 2 of this definition does not apply to a hospital:

a. At which the inpatients are predominantly individuals under 18 years of age; or

b. Which does not offer nonemergency obstetric services as of December 21, 1987.

"DRG cases" means medical/surgical cases subject to payment on the basis of DRGs. DRG cases do not include per diem cases.

"DRG relative weight" means the average standardized costs for cases assigned to that DRG divided by the average standardized costs for cases assigned to all DRGs.

"Groupable cases" means DRG cases having coding data of sufficient quality to support DRG assignment.

"Hospital case-mix index" means the weighted average DRG relative weight for all cases occurring at that hospital.

"Medicaid utilization percentage" is equal to the hospital's total Medicaid inpatient days divided by the hospital's total inpatient days for a given hospital fiscal year. The Medicaid utilization percentage includes days associated with inpatient hospital services provided to Medicaid patients but reimbursed by capitated managed care providers. This definition includes all paid Medicaid days (from DMAS MR reports for fee-for-service days and managed care organization or hospital reports for HMO days) and nonpaid/denied Medicaid days to include medically unnecessary days, inappropriate level of care service days, and days that exceed any maximum day limits (with appropriate documentation). The definition of Medicaid days does not include any general assistance, Family Access to Medical Insurance Security (FAMIS), State and Local Hospitalization (SLH), charity care, low-income, indigent care, uncompensated care, bad debt, or Medicare dually eligible days. It does not include days for newborns not enrolled in Medicaid during the fiscal year even though the mother was Medicaid eligible during the birth.

"Medicare wage index" and the "Medicare geographic adjustment factor" are published annually in the Federal Register by the Health Care Financing Administration. The indices and factors used in this article shall be those in effect in the base year.

"Operating cost-to-charge ratio" equals the hospital's total operating costs, less any applicable operating costs for a psychiatric distinct part unit (DPU), divided by the hospital's total charges, less any applicable charges for a psychiatric DPU. The operating cost-to-charge ratio shall be calculated using data from cost reports from hospital fiscal years ending in the state fiscal year used as the base year.

"Outlier adjustment factor" means a fixed factor published annually in the Federal Register by the Health Care Financing Administration. The factor used in this article shall be the one in effect in the base year.

"Outlier cases" means those DRG cases, including transfer cases, in which the hospital's adjusted operating cost for the case exceeds the hospital's operating outlier threshold for the case.

"Outlier operating fixed loss threshold" means a fixed dollar amount applicable to all hospitals that shall be calculated in the base year so as to result in an expenditure for outliers operating payments equal to 5.1% of total operating payments for DRG cases. The threshold shall be updated in subsequent years using the same inflation values applied to hospital rates.

"Per diem cases" means cases subject to per diem payment and includes (i) covered psychiatric cases in general acute care hospitals and distinct part units (DPUs) of general acute care hospitals (hereinafter "acute care psychiatric cases"), (ii) covered psychiatric cases in freestanding psychiatric facilities licensed as hospitals (hereinafter "freestanding psychiatric cases"), and (iii) rehabilitation cases in general acute care hospitals and rehabilitation hospitals (hereinafter "rehabilitation cases").

"Psychiatric cases" means cases with a principal diagnosis that is a mental disorder as specified in the ICD, as defined in 12VAC30-95-5. Not all mental disorders are covered. For coverage information, see Amount, Duration, and Scope of Services, Supplement 1 to Attachment 3.1 A & B (12VAC30-50-95 through 12VAC30-50-310). The limit of coverage of 21 days in a 60-day period for the same or similar diagnosis shall continue to apply to adult psychiatric cases.

"Psychiatric operating cost-to-charge ratio" for the psychiatric DPU of a general acute care hospital means the hospital's operating costs for a psychiatric DPU divided by the hospital's charges for a psychiatric DPU. In the base year, this ratio shall be calculated as described in the definition of "operating cost-to-charge ratio" in this subsection, using data from psychiatric DPUs.

"Readmissions" means when patients are readmitted to the same hospital for the same or a similar diagnosis within five days of discharge. Such cases shall be considered a continuation of the same stay and shall not be treated as new cases. Similar diagnoses shall be defined as ICD diagnosis

codes possessing the same first three digits. As used here, the term "ICD" is defined in 12VAC30-95-5.

"Rehabilitation operating cost-to-charge ratio" for a rehabilitation unit or hospital means the provider's operating costs divided by the provider's charges. In the base year, this ratio shall be calculated as described in the definition of "operating cost-to-charge ratio" in this subsection, using data from rehabilitation units or hospitals.

"Statewide average labor portion of operating costs" means a fixed percentage applicable to all hospitals. The percentage shall be periodically revised using the most recent reliable data from the Virginia Health Information (VHI), or its successor.

"Transfer cases" means DRG cases involving patients (i) who are transferred from one general acute care hospital to another for related care or (ii) who are discharged from one general acute care hospital and admitted to another for the same or a similar diagnosis within five days of that discharge. Similar diagnoses shall be defined as ICD diagnosis codes possessing the same first three digits. As used here, the term "ICD" is defined in 12VAC30-95-5.

"Type One" hospitals" means those hospitals that were state-owned teaching hospitals on January 1, 1996.

"Type Two" hospitals" means all other hospitals.

"Ungroupable cases" means cases assigned to DRG 469 (principal diagnosis invalid as discharge diagnosis) and DRG 470 (ungroupable) as determined by the AP-DRG Grouper.

D. The All Patient Diagnosis Related Groups (AP-DRG) Grouper shall be used in the DRG payment system. Until notification of a change is given, Version 14.0 of this grouper shall be used. DMAS shall notify hospitals when updating the system to later grouper versions.

E. The primary data sources used in the development of the DRG payment methodology were the department's hospital computerized claims history file and the cost report file. The claims history file captures available claims data from all enrolled, cost-reporting general acute care hospitals, including Type One hospitals. The cost report file captures audited cost and charge data from all enrolled general acute care hospitals, including Type One hospitals. The following table identifies key data elements that were used to develop the DRG payment methodology and that will be used when the system is recalibrated and rebased.

Data Elements for DRG Payment Methodology	
Data Elements	Source
Total charges for each groupable case	Claims history file
Number of groupable cases in each DRG	Claims history file
Total number of groupable cases	Claims history file
Total charges for each DRG case	Claims history file
Total number of DRG cases	Claims history file
Total charges for each acute care psychiatric case	Claims history file
Total number of acute care psychiatric days for each acute care hospital	Claims history file
Total charges for each freestanding psychiatric case	Medicare cost reports
Total number of psychiatric days for each freestanding psychiatric hospital	Medicare cost reports
Total charges for each rehabilitation case	Claims history file
Total number of rehabilitation days for each acute care and freestanding rehabilitation hospital	Claims history file
Operating cost-to-charge ratio for each hospital	Cost report file
Operating cost-to-charge ratio for each freestanding psychiatric facility licensed as a hospital	Medicare cost reports
Psychiatric operating cost-to-charge ratio for the psychiatric DPU of each general acute care hospital	Cost report file
Rehabilitation cost-to-charge ratio for each rehabilitation unit or hospital	Cost report file
Statewide average labor portion of operating costs	VHI
Medicare wage index for each hospital	Federal Register
Medicare geographic adjustment factor for each hospital	Federal Register
Outlier operating fixed loss threshold	Claims history file
Outlier adjustment factor	Federal Register

12VAC30-70-281. Payment for direct medical education costs of nursing schools, paramedical programs, and graduate medical education for interns and residents.

A. Direct medical education costs of nursing schools and paramedical programs shall continue to be paid on an allowable cost basis.

1. Payments for these direct medical education costs shall be made in estimated quarterly lump sum amounts and settled at the hospital's fiscal year end.

~~B.~~ 2. Final payment for these direct medical education (DMedEd) costs shall be the sum of the fee-for-service DMedEd payment and the managed care DMedEd payment. Fee-for-service DMedEd payment is the ratio of Medicaid inpatient costs to total allowable costs, times total DMedEd costs. Managed care DMedEd payment is equal to the managed care days times the ratio of fee-for-service DMedEd payments to fee-for-service days.

~~C.~~ B. Effective with cost reporting periods beginning on or after July 1, 2002, direct graduate medical education (GME) costs for interns and residents shall be reimbursed on a per-resident prospective basis, subject to cost settlement as outlined in this subsection ~~E of this section~~ except that on or after April 1, 2012, payment for direct GME for interns and residents for Type One hospitals shall be 100% of allowable costs as outlined in subsection C of this section.

~~D.~~ 1. The ~~new~~ methodology provides for the determination of a hospital-specific base period per-resident amount to initially be calculated from cost reports with fiscal years ending in state fiscal year 1998 or as may be ~~re-based~~ rebased in the future and provided to the public in an agency guidance document. The per resident amount for new qualifying facilities shall be calculated from the most recently settled cost report. This per-resident amount shall be calculated by dividing a hospital's Medicaid allowable direct GME costs for the base period by its number of interns and residents in the base period yielding the base amount.

~~E.~~ 2. The base amount shall be updated annually by the ~~DRI-Virginia~~ moving average values in the Virginia-Specific Hospital Input Price Index as ~~compiled and published by DRI-WEFA, Inc.~~ described in ~~(12VAC30-70-351)~~ 12VAC30-70-351. The updated per-resident base amount will then be multiplied by the weighted number of full-time equivalent (FTE) interns and residents as reported on the annual cost report to determine the total Medicaid direct GME amount allowable for each year. Payments for direct GME costs shall be made in estimated quarterly lump sum amounts and settled at the hospital's fiscal year end based on the actual number of FTEs reported in the cost reporting period. The total Medicaid direct GME allowable amount shall be allocated to inpatient and outpatient services based on Medicaid's share of costs under each part.

C. Effective April 1, 2012, Type One hospitals shall be reimbursed 100% of Medicaid allowable fee-for-service (FFS) and managed care organization (MCO) GME costs for interns and residents.

1. Type One hospitals shall submit annually separate FFS and MCO GME cost schedules, approved by the agency, using GME per diems and GME ratios of cost to charges (RCCs) from the Medicare and Medicaid cost reports and FFS and MCO days and charges. Type One hospitals shall provide information on managed care days and charges in a format similar to FFS.

2. Interim lump sum GME payments for interns and residents shall be made quarterly based on the total cost from the most recently audited cost report divided by four and will be final settled in the audited cost report for the fiscal year end in which the payments are made.

~~F.~~ D. Direct medical education shall not be a reimbursable cost in freestanding psychiatric facilities licensed as hospitals.

12VAC30-70-291. Payment for indirect medical education costs.

A. Hospitals shall be eligible to receive payments for indirect medical education (IME). Out-of-state cost reporting hospitals are eligible for this payment only if they have Virginia Medicaid utilization in the base year of at least 12% of total Medicaid days. These payments recognize the increased use of ancillary services associated with the educational process and the higher case-mix intensity of teaching hospitals. The payments for indirect medical education shall be made in estimated quarterly lump sum amounts and settled at the hospital's fiscal year end.

B. Final payment for IME shall be determined as follows:

1. Type One hospitals shall receive an IME payment equal to the hospital's Medicaid operating reimbursement times an IME percentage determined as follows:

IME Percentage for Type One Hospitals = [1.89 X $((1 + r)^{0.405}-1)$] X (IME Factor)

An IME factor shall be calculated for each Type One hospital and shall equal a factor that, when used in the calculation of the IME percentage, shall cause the resulting IME payments to equal what the IME payments would be with an IME factor of one, plus an amount equal to the difference between operating payments using the adjustment factor specified in subdivision B 1 of 12VAC30-70-331 and operating payments using an adjustment factor of one in place of the adjustment factor specified in subdivision B 1 of 12VAC30-70-331.

2. Type Two hospitals shall receive an IME payment equal to the hospital's Medicaid operating reimbursement times an IME percentage determined as follows:

IME Percentage for Type Two Hospitals = [1.89 X $((1 + r)^{0.405}-1)$] X 0.5695

In both equations, r is the ratio of full-time equivalent residents to staffed beds, excluding nursery beds. The IME payment shall be calculated each year using the most recent reliable data regarding the number of full-time equivalent residents and the number of staffed beds, excluding nursery beds.

C. An additional IME payment shall be made for inpatient hospital services provided to Medicaid patients but reimbursed by capitated managed care providers.

~~This~~ 1. For Type Two hospitals, this payment shall be equal to the hospital's hospital specific operating rate per case, as determined in 12VAC30-70-311, times the hospital's HMO paid discharges times the hospital's IME percentage, as determined in subsection B of this section.

2. For Type One hospitals, this payment shall be equal to the hospital's hospital-specific operating rate per case, as determined in 12VAC30-70-311, times the hospital's HMO paid discharges times the hospital's IME percentage, as determined in subsection B of this section. Effective April 1, 2012, the operating rate per case used in the formula shall be revised to reflect an adjustment factor of one and case-mix adjusted by multiplying the operating rate per case in this subsection by the weight per case for FFS discharges that is determined during rebasing.

D. An additional IME payment not to exceed $200,000 in total shall be apportioned among Type Two hospitals, excluding freestanding children's hospitals, with Medicaid NICU utilization in excess of 50% as reported to the Department of Medical Assistance Services as of March 1, 2004. These payments shall be apportioned based on each eligible hospital's percentage of Medicaid NICU patient days relative to the total of these days among eligible hospitals as reported by March 1, 2004.

E. An additional IME payment not to exceed $500,000 in total shall be apportioned among Type Two hospitals, excluding freestanding children's hospitals, with Medicaid NICU days in excess of 4,500 as reported to the Department of Medical Assistance Services as of March 1, 2005, that do not otherwise receive an additional IME payment under subsection D of this section. These payments shall be apportioned based on each eligible hospital's percentage of Medicaid NICU patient days relative to the total of these days among eligible hospitals as reported by March 1, 2003.

F. Effective July 1, 2013, DMAS shall calculate an IME factor for Virginia freestanding children's hospitals with greater than 50% Medicaid utilization in 2009. Total payments for IME in combination with other payments for freestanding children's hospitals with greater than 50% Medicaid utilization in 2009 shall not exceed the federal uncompensated care cost limit to which disproportionate share hospital payments are subject.

12VAC30-80-20. Services that are reimbursed on a cost basis.

A. Payments for services listed below shall be on the basis of reasonable cost following the standards and principles applicable to the Title XVIII Program with the exception provided for in subdivision D 1 d of this section. The upper limit for reimbursement shall be no higher than payments for Medicare patients on a facility by facility basis in accordance with 42 CFR 447.321 and 42 CFR 447.325. In no instance, however, shall charges for beneficiaries of the program be in excess of charges for private patients receiving services from the provider. The professional component for emergency room physicians shall continue to be uncovered as a component of the payment to the facility.

B. Reasonable costs will be determined from the filing of a uniform cost report by participating providers. The cost reports are due not later than 150 days after the provider's fiscal year end. If a complete cost report is not received within 150 days after the end of the provider's fiscal year, the Program shall take action in accordance with its policies to assure that an overpayment is not being made. The cost report will be judged complete when DMAS has all of the following:

1. Completed cost reporting form(s) provided by DMAS, with signed certification(s);

2. The provider's trial balance showing adjusting journal entries;

3. The provider's financial statements including, but not limited to, a balance sheet, a statement of income and expenses, a statement of retained earnings (or fund balance), and a statement of changes in financial position;

4. Schedules that reconcile financial statements and trial balance to expenses claimed in the cost report;

5. Depreciation schedule or summary;

6. Home office cost report, if applicable; and

7. Such other analytical information or supporting documents requested by DMAS when the cost reporting forms are sent to the provider.

C. Item 398 D of the 1987 Appropriation Act (as amended), effective April 8, 1987, eliminated reimbursement of return on equity capital to proprietary providers.

D. The services that are cost reimbursed are:

1. Outpatient hospital services, including rehabilitation hospital outpatient services and excluding laboratory services.

a. Definitions. The following words and terms when used in this regulation shall have the following meanings when applied to emergency services unless the context clearly indicates otherwise:

"All-inclusive" means all emergency department and ancillary service charges claimed in association with the

emergency room visit, with the exception of laboratory services.

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

"Emergency hospital services" means services that are necessary to prevent the death or serious impairment of the health of the recipient. The threat to the life or health of the recipient necessitates the use of the most accessible hospital available that is equipped to furnish the services.

"Recent injury" means an injury that has occurred less than 72 hours prior to the emergency department visit.

b. Scope. DMAS shall differentiate, as determined by the attending physician's diagnosis, the kinds of care routinely rendered in emergency departments and reimburse for nonemergency care rendered in emergency departments at a reduced rate.

(1) With the exception of laboratory services, DMAS shall reimburse at a reduced and all-inclusive reimbursement rate for all services rendered in emergency departments that DMAS determines were nonemergency care.

(2) Services determined by the attending physician to be emergencies shall be reimbursed under the existing methodologies and at the existing rates.

(3) Services performed by the attending physician that may be emergencies shall be manually reviewed. If such services meet certain criteria, they shall be paid under the methodology for subdivision 1 b (2) of this subsection. Services not meeting certain criteria shall be paid under the methodology of subdivision 1 b (1) of this subsection. Such criteria shall include, but not be limited to:

(a) The initial treatment following a recent obvious injury.

(b) Treatment related to an injury sustained more than 72 hours prior to the visit with the deterioration of the symptoms to the point of requiring medical treatment for stabilization.

(c) The initial treatment for medical emergencies including indications of severe chest pain, dyspnea, gastrointestinal hemorrhage, spontaneous abortion, loss of consciousness, status epilepticus, or other conditions considered life threatening.

(d) A visit in which the recipient's condition requires immediate hospital admission or the transfer to another facility for further treatment or a visit in which the recipient dies.

(e) Services provided for acute vital sign changes as specified in the provider manual.

(f) Services provided for severe pain when combined with one or more of the other guidelines.

(4) Payment shall be determined based on ICD diagnosis codes and necessary supporting documentation. As used here, the term "ICD" is defined in 12VAC30-95-5.

(5) DMAS shall review on an ongoing basis the effectiveness of this program in achieving its objectives and for its effect on recipients, physicians, and hospitals. Program components may be revised subject to achieving program intent, the accuracy and effectiveness of the ICD code designations, and the impact on recipients and providers. As used here, the term "ICD" is defined in 12VAC30-95-5.

c. Limitation of allowable cost. Effective for services on and after July 1, 2003, reimbursement of Type Two hospitals for outpatient services shall be at various percentages as noted in subdivisions 1 c (1) and 1 c (2) of this subsection of allowable cost, with cost to be determined as provided in subsections A, B, and C of this section. For hospitals with fiscal years that do not begin on July 1, outpatient costs, both operating and capital, for the fiscal year in progress on that date shall be apportioned between the time period before and the time period after that date, based on the number of calendar months in the cost reporting period, falling before and after that date.

(1) Type One hospitals.

(a) Effective July 1, 2003, through June 30, 2010, hospital outpatient operating reimbursement shall be at 94.2% of allowable cost and capital reimbursement shall be at 90% of allowable cost.

(b) Effective July 1, 2010, through September 30, 2010, hospital outpatient operating reimbursement shall be at 91.2% of allowable cost and capital reimbursement shall be at 87% of allowable cost.

(c) Effective October 1, 2010, through June 30, 2011, hospital outpatient operating reimbursement shall be at 94.2% of allowable cost and capital reimbursement shall be at 90% of allowable cost.

(d) Effective July 1, 2011, hospital outpatient operating reimbursement shall be at 90.2% of allowable cost and capital reimbursement shall be at 86% of allowable cost.

(2) Type Two hospitals.

(a) Effective July 1, 2003, through June 30, 2010, hospital outpatient operating and capital reimbursement shall be 80% of allowable cost.

(b) Effective July 1, 2010, through September 30, 2010, hospital outpatient operating and capital reimbursement shall be 77% of allowable cost.

(c) Effective October 1, 2010, through June 30, 2011, hospital outpatient operating and capital reimbursement shall be 80% of allowable cost.

(d) Effective July 1, 2011, hospital outpatient operating and capital reimbursement shall be 76% of allowable cost.

d. Payment for direct medical education costs of nursing schools, paramedical programs and graduate medical education for interns and residents.

(1) Direct medical education costs of nursing schools and paramedical programs shall continue to be paid on an allowable cost basis.

(2) Effective with cost reporting periods beginning on or after July 1, 2002, direct graduate medical education (GME) costs for interns and residents shall be reimbursed on a per-resident prospective basis. See 12VAC30-70-281 for prospective payment methodology for graduate medical education for interns and residents.

2. Rehabilitation agencies or comprehensive outpatient rehabilitation.

a. Effective July 1, 2009, rehabilitation agencies or comprehensive outpatient rehabilitation facilities that are operated by community services boards or state agencies shall be reimbursed their costs. For reimbursement methodology applicable to all other rehabilitation agencies, see 12VAC30-80-200.

b. Effective October 1, 2009, rehabilitation agencies or comprehensive outpatient rehabilitation facilities operated by state agencies shall be reimbursed their costs. For reimbursement methodology applicable to all other rehabilitation agencies, see 12VAC30-80-200.

3. Supplement payments to Type One hospitals for outpatient services.

a. In addition to payments for services set forth elsewhere in the State Plan, DMAS makes supplemental payments to qualifying state government owned or operated hospitals for outpatient services furnished to Medicare members on or after July 1, 2010. To qualify for a supplement payment, the hospital must be part of the state academic health system or part of an academic health system that operates under a state authority.

b. The amount of the supplemental payment made to each qualifying hospital shall be equal to the difference between the total allowable cost and the amount otherwise actually paid for the services by the Medicaid program based on cost settlement.

c. Payment for furnished services under this section shall be paid at settlement of the cost report.

12VAC30-80-30. Fee-for-service providers.

A. Payment for the following services, except for physician services, shall be the lower of the state agency fee schedule (12VAC30-80-190 has information about the state agency fee schedule) or actual charge (charge to the general public):

1. Physicians' services. Payment for physician services shall be the lower of the state agency fee schedule or actual charge (charge to the general public). The following limitations shall apply to emergency physician services.

a. Definitions. The following words and terms, when used in this subdivision 1 shall have the following meanings when applied to emergency services unless the context clearly indicates otherwise:

"All-inclusive" means all emergency service and ancillary service charges claimed in association with the emergency department visit, with the exception of laboratory services.

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

"Emergency physician services" means services that are necessary to prevent the death or serious impairment of the health of the recipient. The threat to the life or health of the recipient necessitates the use of the most accessible hospital available that is equipped to furnish the services.

"Recent injury" means an injury that has occurred less than 72 hours prior to the emergency department visit.

b. Scope. DMAS shall differentiate, as determined by the attending physician's diagnosis, the kinds of care routinely rendered in emergency departments and reimburse physicians for nonemergency care rendered in emergency departments at a reduced rate.

(1) DMAS shall reimburse at a reduced and all-inclusive reimbursement rate for all physician services rendered in emergency departments that DMAS determines are nonemergency care.

(2) Services determined by the attending physician to be emergencies shall be reimbursed under the existing methodologies and at the existing rates.

(3) Services determined by the attending physician that may be emergencies shall be manually reviewed. If such services meet certain criteria, they shall be paid under the methodology in subdivision 1 b (2) of this subsection. Services not meeting certain criteria shall be paid under the methodology in subdivision 1 b (1) of this subsection. Such criteria shall include, but not be limited to:

(a) The initial treatment following a recent obvious injury.

(b) Treatment related to an injury sustained more than 72 hours prior to the visit with the deterioration of the symptoms to the point of requiring medical treatment for stabilization.

(c) The initial treatment for medical emergencies including indications of severe chest pain, dyspnea, gastrointestinal hemorrhage, spontaneous abortion, loss of consciousness, status epilepticus, or other conditions considered life threatening.

(d) A visit in which the recipient's condition requires immediate hospital admission or the transfer to another facility for further treatment or a visit in which the recipient dies.

(e) Services provided for acute vital sign changes as specified in the provider manual.

(f) Services provided for severe pain when combined with one or more of the other guidelines.

(4) Payment shall be determined based on ICD diagnosis codes and necessary supporting documentation. As used here, the term "ICD" is defined in 12VAC30-95-5.

(5) DMAS shall review on an ongoing basis the effectiveness of this program in achieving its objectives and for its effect on recipients, physicians, and hospitals. Program components may be revised subject to achieving program intent objectives, the accuracy and effectiveness of the ICD code designations, and the impact on recipients and providers. As used here, the term "ICD" is defined in 12VAC30-95-5.

2. Dentists' services.

3. Mental health services including: (i) community mental health services, (ii) services of a licensed clinical psychologist, or (iii) mental health services provided by a physician.

a. Services provided by licensed clinical psychologists shall be reimbursed at 90% of the reimbursement rate for psychiatrists.

b. Services provided by independently enrolled licensed clinical social workers, licensed professional counselors or licensed clinical nurse specialists-psychiatric shall be reimbursed at 75% of the reimbursement rate for licensed clinical psychologists.

4. Podiatry.

5. Nurse-midwife services.

6. Durable medical equipment (DME) and supplies.

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

"DMERC" means the Durable Medical Equipment Regional Carrier rate as published by the Centers for Medicare and Medicaid Services at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html.

"HCPCS" means the Healthcare Common Procedure Coding System, Medicare's National Level II Codes, HCPCS 2006 (Eighteenth edition), as published by Ingenix, as may be periodically updated.

a. Obtaining prior authorization shall not guarantee Medicaid reimbursement for DME.

b. The following shall be the reimbursement method used for DME services:

(1) If the DME item has a DMERC rate, the reimbursement rate shall be the DMERC rate minus 10%.

(2) For DME items with no DMERC rate, the agency shall use the agency fee schedule amount. The reimbursement rates for DME and supplies shall be listed in the DMAS Medicaid Durable Medical Equipment (DME) and Supplies Listing and updated periodically. The agency fee schedule shall be available on the agency website at www.dmas.virginia.gov.

(3) If a DME item has no DMERC rate or agency fee schedule rate, the reimbursement rate shall be the manufacturer's net charge to the provider, less shipping and handling, plus 30%. The manufacturer's net charge to the provider shall be the cost to the provider minus all available discounts to the provider. Additional information specific to how DME providers, including manufacturers who are enrolled as providers, establish and document their cost or costs for DME codes that do not have established rates can be found in the relevant agency guidance document.

c. DMAS shall have the authority to amend the agency fee schedule as it deems appropriate and with notice to providers. DMAS shall have the authority to determine alternate pricing, based on agency research, for any code that does not have a rate.

d. The reimbursement for incontinence supplies shall be by selective contract. Pursuant to § 1915(a)(1)(B) of the Social Security Act and 42 CFR 431.54(d), the Commonwealth assures that adequate services/devices shall be available under such arrangements.

e. Certain durable medical equipment used for intravenous therapy and oxygen therapy shall be bundled under specified procedure codes and reimbursed as determined by the agency. Certain services/durable medical equipment such as service maintenance agreements shall be bundled under specified procedure codes and reimbursed as determined by the agency.

(1) Intravenous therapies. The DME for a single therapy, administered in one day, shall be reimbursed at the established service day rate for the bundled durable medical equipment and the standard pharmacy payment, consistent with the ingredient cost as described in 12VAC30-80-40, plus the pharmacy service day and dispensing fee. Multiple applications of the same therapy shall be included in one service day rate of reimbursement. Multiple applications of different therapies administered in one day shall be reimbursed for the bundled durable medical equipment service day rate as follows: the most expensive therapy shall be reimbursed at 100% of cost; the second and all subsequent most expensive therapies shall be reimbursed

at 50% of cost. Multiple therapies administered in one day shall be reimbursed at the pharmacy service day rate plus 100% of every active therapeutic ingredient in the compound (at the lowest ingredient cost methodology) plus the appropriate pharmacy dispensing fee.

(2) Respiratory therapies. The DME for oxygen therapy shall have supplies or components bundled under a service day rate based on oxygen liter flow rate or blood gas levels. Equipment associated with respiratory therapy may have ancillary components bundled with the main component for reimbursement. The reimbursement shall be a service day per diem rate for rental of equipment or a total amount of purchase for the purchase of equipment. Such respiratory equipment shall include, but not be limited to, oxygen tanks and tubing, ventilators, noncontinuous ventilators, and suction machines. Ventilators, noncontinuous ventilators, and suction machines may be purchased based on the individual patient's medical necessity and length of need.

(3) Service maintenance agreements. Provision shall be made for a combination of services, routine maintenance, and supplies, to be known as agreements, under a single reimbursement code only for equipment that is recipient owned. Such bundled agreements shall be reimbursed either monthly or in units per year based on the individual agreement between the DME provider and DMAS. Such bundled agreements may apply to, but not necessarily be limited to, either respiratory equipment or apnea monitors.

7. Local health services.

8. Laboratory services (other than inpatient hospital).

9. Payments to physicians who handle laboratory specimens, but do not perform laboratory analysis (limited to payment for handling).

10. X-Ray services.

11. Optometry services.

12. Medical supplies and equipment.

13. Home health services. Effective June 30, 1991, cost reimbursement for home health services is eliminated. A rate per visit by discipline shall be established as set forth by 12VAC30-80-180.

14. Physical therapy; occupational therapy; and speech, hearing, language disorders services when rendered to noninstitutionalized recipients.

15. Clinic services, as defined under 42 CFR 440.90.

16. Supplemental payments for services provided by Type I physicians.

a. In addition to payments for physician services specified elsewhere in this State Plan, DMAS provides supplemental payments to Type I physicians for furnished services provided on or after July 2, 2002. A Type I physician is a member of a practice group organized by or under the control of a state academic health system or an academic health system that operates under a state authority and includes a hospital, who has entered into contractual agreements for the assignment of payments in accordance with 42 CFR 447.10.

b. Effective July 2, 2002, the supplemental payment amount for Type I physician services shall be the difference between the Medicaid payments otherwise made for Type I physician services and Medicare rates. Effective August 13, 2002, the supplemental payment amount for Type I physician services shall be the difference between the Medicaid payments otherwise made for physician services and 143% of Medicare rates. ~~This percentage was determined by dividing the total commercial allowed amounts for Type I physicians for at least the top five commercial insurers in CY 2004 by what Medicare would have allowed. The average commercial allowed amount was determined by multiplying the relative value units times the conversion factor for RBRVS procedures and by multiplying the unit cost times anesthesia units for anesthesia procedures for each insurer and practice group with Type I physicians and summing for all insurers and practice groups. The Medicare equivalent amount was determined by multiplying the total commercial relative value units for Type I physicians times the Medicare conversion factor for RBRVS procedures and by multiplying the Medicare unit cost times total commercial anesthesia units for anesthesia procedures for all Type I physicians and summing.~~ Effective January 3, 2012, the supplemental payment amount for Type I physician services shall be the difference between the Medicaid payments otherwise made for physician services and 181% of Medicare rates. The methodology for determining the Medicare equivalent of the average commercial rate is described in 12VAC30-80-300.

c. Supplemental payments shall be made quarterly no later than 90 days after the end of the quarter.

~~d. Payment will not be made to the extent that this would duplicate payments based on physician costs covered by the supplemental payments.~~

17. Supplemental payments for services provided by physicians at Virginia freestanding children's hospitals.

a. In addition to payments for physician services specified elsewhere in this State Plan, DMAS provides supplemental payments to Virginia freestanding children's hospital physicians providing services at freestanding children's hospitals with greater than 50% Medicaid inpatient utilization in state fiscal year 2009 for furnished services provided on or after July 1, 2011. A freestanding children's hospital physician is a member of a practice group (i) organized by or under control of a qualifying Virginia freestanding children's hospital, or (ii) who has entered into contractual agreements for

provision of physician services at the qualifying Virginia freestanding children's hospital and that is designated in writing by the Virginia freestanding children's hospital as a practice plan for the quarter for which the supplemental payment is made subject to DMAS approval. The freestanding children's hospital physicians also must have entered into contractual agreements with the practice plan for the assignment of payments in accordance with 42 CFR 447.10.

b. Effective July 1, 2011, the supplemental payment amount for freestanding children's hospital physician services shall be the difference between the Medicaid payments otherwise made for freestanding children's hospital physician services and 143% of Medicare rates as defined in the supplemental payment calculation for Type I physician services subject to the following reduction. Final payments shall be reduced on a ~~pro-rated~~ prorated basis so that total payments for freestanding children's hospital physician services are $400,000 less annually than would be calculated based on the formula in the previous sentence. Payments shall be made on the same schedule as Type I physicians.

18. Supplemental payments to nonstate government-owned or operated clinics.

a. In addition to payments for clinic services specified elsewhere in the regulations, DMAS provides supplemental payments to qualifying nonstate government-owned or operated clinics for outpatient services provided to Medicaid patients on or after July 2, 2002. Clinic means a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. Outpatient services include those furnished by or under the direction of a physician, dentist, or other medical professional acting within the scope of his license to an eligible individual. Effective July 1, 2005, a qualifying clinic is a clinic operated by a community services board. The state share for supplemental clinic payments will be funded by general fund appropriations.

b. The amount of the supplemental payment made to each qualifying nonstate government-owned or operated clinic is determined by:

(1) Calculating for each clinic the annual difference between the upper payment limit attributed to each clinic according to subdivision 18 d of this subsection and the amount otherwise actually paid for the services by the Medicaid program;

(2) Dividing the difference determined in subdivision 18 b (1) of this subsection for each qualifying clinic by the aggregate difference for all such qualifying clinics; and

(3) Multiplying the proportion determined in subdivision 18 b (2) of this subsection by the aggregate upper payment limit amount for all such clinics as determined in accordance with 42 CFR 447.321 less all payments made to such clinics other than under this section.

c. Payments for furnished services made under this section may be made in one or more installments at such times, within the fiscal year or thereafter, as is determined by DMAS.

d. To determine the aggregate upper payment limit referred to in subdivision 18 b (3) of this subsection, Medicaid payments to nonstate government-owned or operated clinics will be divided by the "additional factor" whose calculation is described in Attachment 4.19-B, Supplement 4 (12VAC30-80-190 B 2) in regard to the state agency fee schedule for RBRVS. Medicaid payments will be estimated using payments for dates of service from the prior fiscal year adjusted for expected claim payments. Additional adjustments will be made for any program changes in Medicare or Medicaid payments.

19. Personal assistance services (PAS) for individuals enrolled in the Medicaid Buy-In program described in 12VAC30-60-200. These services are reimbursed in accordance with the state agency fee schedule described in 12VAC30-80-190. The state agency fee schedule is published on the DMAS website ~~(http://dmasva.dmas.virginia.gov)~~ at http://www.dmas.virginia.gov.

B. Hospice services payments must be no lower than the amounts using the same methodology used under Part A of Title XVIII, and take into account the room and board furnished by the facility, equal to at least 95% of the rate that would have been paid by the state under the plan for facility services in that facility for that individual. Hospice services shall be paid according to the location of the service delivery and not the location of the agency's home office.

12VAC30-80-300. Medicare equivalent of average commercial rate.

Physician supplemental payment amounts shall be calculated using the Medicare equivalent of the average commercial rate (ACR) methodology prescribed by CMS. The following methodology describes the calculation of the supplemental payment. To compute the ACR by commercial payers, calculate the average amount reimbursed for each procedure code (e.g., CPT or HCPCS) by the top five commercial payers for a specified base period. Data from Medicare, Workers' Compensation, and other noncommercial payers and codes not reimbursed by Medicaid are excluded.

(Payer 1 + Payer 2 + Payer 3 + Payer 4 + Payer 5) / (5) = Average Commercial Reimbursement

To compute the reimbursement ceiling, multiply the average reimbursement rate as determined by the number of claims recorded in Medicaid Management Information System (MMIS) for each procedure code that was rendered to Medicaid members by eligible physicians during the base period. Add the product for all procedure codes. This total represents the total reimbursement ceiling.

(Average Commercial Reimbursement) X (Medicaid Count) = Total Reimbursement Ceiling for each Procedure Code

Sum of Total Reimbursement Ceiling for each Procedure Code = Total Reimbursement Ceiling

To determine the Medicare equivalent to the reimbursement ceiling, for each of the billing codes used to determine the reimbursement ceiling, multiply the Medicare rate by the number of claims recorded in MMIS for each procedure code that was rendered to Medicaid members during the base period. Add the product for all procedure codes. This sum represents the total Medicare reimbursement that would have been received. Divide the reimbursement ceiling (commercial payment) by Medicare reimbursement. This ratio expresses the ACR as a percentage of Medicare.

(Medicare Rate) X (Medicaid Count) = Total Medicare Reimbursement for each Procedure Code

Sum of Total Medicare Reimbursement for each Procedure Code = Total Medicare Reimbursement

(Total Reimbursement Ceiling) / (Total Medicare Reimbursement) = Medicare equivalent of the ACR

This single ratio is applied to the Medicare rates for reimbursable Medicaid practitioner services to determine the total allowable Medicaid payment, including both the regular base payment and supplemental payment.

(Medicare equivalent of the ACR) X (Medicare rate per CPT Code for all applicable CPT Codes) = Total Allowable Medicaid Payment

Total Allowable Medicaid Payment – Medicaid Base Payment = Maximum Supplemental Payment

The Medicare equivalent of the ACR demonstration shall be updated every three years.

VA.R. Doc. No. R15-3335; Filed December 10, 2014, 11:30 a.m.

Proposed Regulation

Title of Regulation: **12VAC30-80. Methods and Standards for Establishing Payment Rates; Other Types of Care (amending 12VAC30-80-20, 12VAC30-80-40; adding 12VAC30-80-36).**

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

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: February 27, 2015.

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

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

Item 307 XX of Chapter 806 of the 2013 Acts of the Assembly gave the agency the initial authority to implement the enhanced ambulatory patient group (EAPG) reimbursement methodology for outpatient hospital services. This authority is continued in Item 301 TT of Chapter 3 of the 2014 Acts of Assembly, Special Session I.

Purpose: The purpose of this action is to produce a permanent regulation to implement a prospective payment methodology for outpatient hospital services. The current cost-based methodology is out of date, inefficient, and costly. DMAS is proposing to implement the enhanced ambulatory patient group (EAPG) reimbursement methodology for outpatient hospital services, which is a more efficient and predictable reimbursement methodology for hospitals that furnish services to Medicaid recipients in an outpatient hospital setting.

This action does not have a direct effect on the health, safety, or welfare of Medicaid individuals or the citizens of the Commonwealth.

Substance: Medicaid currently reimburses Type Two hospitals 76% of operating and capital costs for services furnished in an outpatient hospital setting. Type One hospitals are reimbursed separate percentages of costs for operating and capital costs. Cost-based reimbursement is out of date, inefficient, and unpredictable. The proposed prospective EAPG reimbursement methodology is predictable, efficient, and promotes quality of care. DMAS converted inpatient hospital services to a similar prospective reimbursement methodology, diagnosis-related groups (DRGs), in the 1990s. Inpatient hospital services are reimbursed case rates for DRGs on a prospective basis. EAPGs will be used to reimburse outpatient hospital services on a prospective basis as well.

The new EAPG methodology shall define EAPGs as allowed outpatient procedures and ancillary services that reflect similar patient characteristics and resource utilization performed by hospitals in an outpatient setting. Each EAPG group shall be assigned an EAPG relative weight that reflects the relative average cost for each EAPG compared to the relative cost for all other EAPGs. For Type Two hospitals, a statewide base rate for outpatient hospital visits shall be calculated using base year cost data inflated to a rate year. The base year costs shall be adjusted to reflect the agency reimbursement policies for emergency room, laboratory, therapy, and pharmacy services. For Type One hospitals, a separate, budget neutral base rate shall be calculated.

The statewide base rate shall be adjusted to be hospital specific based on the geographic location of the hospital facility. The hospital-specific base rate shall be determined by

adjusting the labor portion of the statewide base rate by the wage index for the hospital's geographic location and adding the nonlabor portion of statewide base rate. The hospital-specific base rate for children's hospitals shall reflect a 5.0% differential. The total allowable reimbursement per visit shall be determined by multiplying the hospital-specific base rate times the sum of the EAPG relative weights assigned to an outpatient hospital visit. To maintain budget neutral expenditures for outpatient hospital services the base rate shall be rebased at least every three years.

The EAPG methodology shall be transitioned over a 3-1/2-year period in 25% increments. The transition rates will be a blend of cost-based reimbursement and EAPG reimbursement. DMAS shall also calculate a budget neutrality adjustment every six months for up to the first six years of implementation.

The EAPG relative weights implemented shall be the weights determined and published periodically by DMAS. The weights will be updated at least every three years at rebasing. New outpatient procedures and new relative weights shall be added as necessary between the scheduled weight and rate updates.

To maintain reimbursement of drug rebates for outpatient hospital services, each drug administered in the outpatient hospital setting shall be reimbursed separately to be eligible for drug rebate claiming.

Issues: The advantages of the regulation are an increase in the efficiency and predictability of reimbursement for outpatient hospital services and reduction of the costs of settlement of reimbursement for outpatient hospital services. This regulatory action poses no disadvantages to the public or the Commonwealth.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. Pursuant to the 2013 Acts of the Assembly, Chapter 806, Item 307 XX, the proposed changes will implement a permanent prospective payment methodology for Medicaid outpatient hospital services. The proposed payment methodology has been in effect since January 1, 2014, under emergency regulations.

Result of Analysis. The benefits likely exceed the costs for most of the proposed changes. A different design would likely yield the same benefits at lower cost for at least one proposed change.

Estimated Economic Impact. Prior to the emergency regulations, Medicaid reimbursed non-teaching hospitals 76 percent of operating and capital costs for services furnished in an outpatient hospital setting. Teaching hospitals were reimbursed separate percentages of costs for operating and capital costs. Pre-emergency reimbursement methodology was a cost-based methodology. The 2013 Acts of the Assembly, Chapter 806, Item 307 XX has given DMAS authority to implement a prospective reimbursement methodology called Enhanced Ambulatory Patient Group (EAPG) methodology in a budget-neutral manner. DMAS implemented EAPG methodology under emergency regulations on January 1, 2014.[1] The proposed changes will make permanent the EAPG methodology that has been in effect since January 2014.

EAPG defines a group of outpatient procedures, encounters, or ancillary services that incorporates International Classification of Disease (ICD) diagnosis codes, Current Procedural Terminology (CPT) codes, and Healthcare Common Procedure Coding System (HCPCS) codes.

The new methodology defines EAPGs as allowed outpatient procedures and ancillary services that reflect similar patient characteristics and resource utilization performed by hospitals in an outpatient setting. Each EAPG group is assigned an EAPG relative weight that reflects the relative average cost for each EAPG compared to the relative cost for all other EAPGs. For non-teaching hospitals, a statewide base rate for outpatient hospital visits is calculated using base year cost data inflated to a rate year. The base year costs are adjusted to reflect the Medicaid reimbursement policies for emergency room, laboratory, therapy, and pharmacy services. For teaching hospitals, a separate, budget neutral base rate is calculated.

The statewide base rate is adjusted to be hospital-specific based on the geographic location of the hospital facility. The hospital-specific base rate is determined by adjusting the labor portion of the statewide base rate by the wage index for the hospital's geographic location and adding the non-labor portion of the statewide base rate. The hospital-specific base rate for children's hospitals reflects a five percent additional payment. The total allowable reimbursement per visit is determined by multiplying the hospital-specific base rate times the sum of the EAPG relative weights assigned to an outpatient hospital visit. To maintain budget neutrality, the base rate will be rebased at least every three years.

The EAPG methodology will be transitioned over a three-and-a-half-year period in 25-percent increments. The transition rates will be a blend of cost-based reimbursement and EAPG reimbursement. DMAS will also calculate a budget neutrality adjustment every six months for up to the first six years of implementation.

The EAPG relative weights implemented are the weights determined and will be published periodically by DMAS. The weights will be updated at least every three years at rebasing. New outpatient procedures and new relative weights will be added as necessary between the scheduled weight and rate updates.

To maintain reimbursement of drug rebates for outpatient hospital services, each drug administered in the outpatient hospital setting is reimbursed separately to be eligible for drug rebate claiming.

This action will likely increase the efficiency of reimbursement for outpatient hospital services. Under the new system, hospitals will receive a fixed payment for a specific procedure. These payments will be adjusted periodically to account for inflation, for cost of living in certain geographical locations, etc, but will not accommodate individual hospitals. Each hospital will receive the same base payment for the same service adjusted for geographic location. Since the reimbursement rate is calculated using cost data from all hospitals, inefficient hospitals will receive less than what they receive under the cost based methodology and efficient hospitals will receive more than what they receive under the cost based methodology. Thus, all hospitals will have an incentive to keep their costs as low as possible to maximize their profit. Lower costs, in turn, will lead to lower reimbursement rates when the rates are adjusted at least every three years. Over time, inefficient hospitals will be forced to improve their efficiency and reduce costs which in turn will push reimbursement rates down to the lowest possible level on a continuing basis.

By budget-neutral design, the new methodology will not increase or decrease the aggregate reimbursement for outpatient hospital services. In fiscal year (FY) 2011, the total Medicaid reimbursement for outpatient hospital services was approximately $103 million. However, individual hospitals will see changes in their reimbursements. While some hospitals will receive more than what they would have received under the previous methodology, some will receive less. Based on FY 2011 data, of the 96 hospitals, 47 will see a reduction totaling approximately $1.9 million which will be transferred to remaining 49 hospitals. The largest loss to a hospital is estimated to be $201,957 while the largest gain is estimated to be $233,124.

The proposed new methodology also provides an extra five percent reimbursement for children's hospitals. This provision will specifically benefit two children's hospitals which are estimated to receive approximately $204,590 more than what they would receive without the five percent extra reimbursement. The rationale for providing a higher reimbursement specifically for children's hospitals is not clear.

In order to be paid for all services, providers will have to code in more detail than they may have been used to. Providers may also wish to purchase the EAPG software to monitor reimbursement. Providers' costs associated with these changes are not expected to be significant.

This action will also increase the predictability of reimbursement for outpatient hospital services. Since fixed rates will be paid for services, the total reimbursement will be driven mainly by utilization and no so much by hospital specific cost factors.

The new methodology is also expected to reduce the costs associated with cost settlement of outpatient hospitals services.

Finally, while there is likely to be some administrative costs on DMAS to modify its information technology to incorporate this methodology, the costs of claim system changes are already included in the fiscal agent contract.

Businesses and Entities Affected. The proposed new methodology affects approximately 110 hospitals currently. Some of the hospitals may be small and qualify as small businesses. While some of the seven managed care organizations may also change their provider reimbursement methodology for outpatient services following this change, this regulation does not require them to do so.

Localities Particularly Affected. The regulations apply throughout the Commonwealth.

Projected Impact on Employment. The new methodology will reduce reimbursement for inefficient hospitals while increasing reimbursement for efficient hospitals. Inefficient hospitals may reduce their demand for labor while efficient hospitals may increase their demand for labor.

Effects on the Use and Value of Private Property. The new methodology will reduce reimbursement for 47 hospitals while increasing reimbursement for 49 hospitals. The asset values of the affected hospitals would be affected depending on the impact on their revenues.

Small Businesses: Costs and Other Effects. Some of the hospitals may be small businesses. The costs and other effects on them would the same as discussed above.

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

Real Estate Development Costs. The proposed amendments are unlikely to affect real estate development costs.

Legal Mandate.

General: The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007.04 of the Code of Virginia and Executive Order Number 17 (2014). Section 2.2-4007.04 requires that such economic impact analyses determine the public benefits and costs of the proposed amendments. Further the report should include but not be limited to:

- the projected number of businesses or other entities to whom the proposed regulation would apply,
- the identity of any localities and types of businesses or other entities particularly affected,
- the projected number of persons and employment positions to be affected,
- the projected costs to affected businesses or entities to implement or comply with the regulation, and
- the impact on the use and value of private property.

Small Businesses: If the proposed regulation will have an adverse effect on small businesses, § 2.2-4007.04 requires that such economic impact analyses include:

• an identification and estimate of the number of small businesses subject to the proposed regulation,

• the projected reporting, recordkeeping, and other administrative costs required for small businesses to comply with the proposed regulation, including the type of professional skills necessary for preparing required reports and other documents,

• a statement of the probable effect of the proposed regulation on affected small businesses, and

• a description of any less intrusive or less costly alternative methods of achieving the purpose of the proposed regulation.

Additionally, pursuant to § 2.2-4007.1, if there is a finding that a proposed regulation may have an adverse impact on small business, the Joint Commission on Administrative Rules (JCAR) is notified at the time the proposed regulation is submitted to the Virginia Register of Regulations for publication. This analysis shall represent DPB's best estimate for the purposes of public review and comment on the proposed regulation.

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[1] DMAS converted inpatient hospital services to a similar prospective reimbursement methodology, Diagnosis-Related Groups (DRGs), in the 1990s. Inpatient hospital services are currently reimbursed case rates for DRGs on a prospective basis.

Agency's Response to Economic Impact Analysis: The agency has reviewed the economic impact analysis prepared by the Department of Planning and Budget regarding the regulations concerning enhanced ambulatory patient group out patient hospital reimbursement methodology. The agency raises no issues with this analysis.

Summary:

The proposed amendments implement a prospective payment methodology for Medicaid outpatient hospital services as provided in Item 301 TT of Chapter 3 of the 2014 Acts of Assembly, Special Session I. The enhanced ambulatory patient group (EAPG) reimbursement methodology for outpatient hospital services, which is currently in place through emergency regulations, assigns outpatient procedures and ancillary services that reflect similar patient characteristics and resource utilization to EAPG codes.

12VAC30-80-20. Services that are reimbursed on a cost basis.

A. Payments for services listed ~~below~~ in this section shall be on the basis of reasonable cost following the standards and principles applicable to the Title XVIII Program with the exception provided for in subdivision D 1 ~~d~~ e of this section. The upper limit for reimbursement shall be no higher than payments for Medicare patients on a facility by facility basis in accordance with 42 CFR 447.321 and 42 CFR 447.325. In no instance, however, shall charges for beneficiaries of the program be in excess of charges for private patients receiving services from the provider. The professional component for emergency room physicians shall continue to be uncovered as a component of the payment to the facility.

B. Reasonable costs will be determined from the filing of a uniform cost report by participating providers. The cost reports are due not later than 150 days after the provider's fiscal year end. If a complete cost report is not received within 150 days after the end of the provider's fiscal year, the Program shall take action in accordance with its policies to assure that an overpayment is not being made. The cost report will be judged complete when DMAS has all of the following:

1. Completed cost reporting form(s) provided by DMAS, with signed certification(s);

2. The provider's trial balance showing adjusting journal entries;

3. The provider's financial statements including, but not limited to, a balance sheet, a statement of income and expenses, a statement of retained earnings (or fund balance), and a statement of changes in financial position;

4. Schedules that reconcile financial statements and trial balance to expenses claimed in the cost report;

5. Depreciation schedule or summary;

6. Home office cost report, if applicable; and

7. Such other analytical information or supporting documents requested by DMAS when the cost reporting forms are sent to the provider.

C. Item 398 D of the 1987 Appropriation Act (as amended), effective April 8, 1987, eliminated reimbursement of return on equity capital to proprietary providers.

D. The services that are cost reimbursed are:

1. ~~Outpatient~~ For dates of service prior to January 1, 2014, outpatient hospital services, including rehabilitation hospital outpatient services and excluding laboratory services.

a. Definitions. The following words and terms when used in this regulation shall have the following meanings when applied to emergency services unless the context clearly indicates otherwise:

"All-inclusive" means all emergency department and ancillary service charges claimed in association with the emergency room visit, with the exception of laboratory services.

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

"Emergency hospital services" means services that are necessary to prevent the death or serious impairment of the health of the recipient. The threat to the life or health of the recipient necessitates the use of the most accessible hospital available that is equipped to furnish the services.

"Recent injury" means an injury that has occurred less than 72 hours prior to the emergency department visit.

b. Scope. DMAS shall differentiate, as determined by the attending physician's diagnosis, the kinds of care routinely rendered in emergency departments and reimburse for nonemergency care rendered in emergency departments at a reduced rate.

(1) With the exception of laboratory services, DMAS shall reimburse at a reduced and all-inclusive reimbursement rate for all services rendered in emergency departments that DMAS determines were nonemergency care.

(2) Services determined by the attending physician to be emergencies shall be reimbursed under the existing methodologies and at the existing rates.

(3) Services performed by the attending physician that may be emergencies shall be manually reviewed. If such services meet certain criteria, they shall be paid under the methodology for subdivision 1 b (2) of this subsection. Services not meeting certain criteria shall be paid under the methodology of subdivision 1 b (1) of this subsection. Such criteria shall include, but not be limited to:

(a) The initial treatment following a recent obvious injury.

(b) Treatment related to an injury sustained more than 72 hours prior to the visit with the deterioration of the symptoms to the point of requiring medical treatment for stabilization.

(c) The initial treatment for medical emergencies including indications of severe chest pain, dyspnea, gastrointestinal hemorrhage, spontaneous abortion, loss of consciousness, status epilepticus, or other conditions considered life threatening.

(d) A visit in which the recipient's condition requires immediate hospital admission or the transfer to another facility for further treatment or a visit in which the recipient dies.

(e) Services provided for acute vital sign changes as specified in the provider manual.

(f) Services provided for severe pain when combined with one or more of the other guidelines.

(4) Payment shall be determined based on ICD diagnosis codes and necessary supporting documentation. As used here, the term "ICD" is defined in 12VAC30-95-5.

(5) DMAS shall review on an ongoing basis the effectiveness of this program in achieving its objectives and for its effect on recipients, physicians, and hospitals. Program components may be revised subject to achieving program intent, the accuracy and effectiveness of the ICD code designations, and the impact on recipients and providers. As used here, the term "ICD" is defined in 12VAC30-95-5.

c. Limitation of allowable cost. Effective for services on and after July 1, 2003, reimbursement of Type Two hospitals for outpatient services shall be at various percentages as noted in subdivisions 1 c (1) and 1 c (2) of this subsection of allowable cost, with cost to be determined as provided in subsections A, B, and C of this section. For hospitals with fiscal years that do not begin on July 1, outpatient costs, both operating and capital, for the fiscal year in progress on that date shall be apportioned between the time period before and the time period after that date, based on the number of calendar months in the cost reporting period, falling before and after that date.

(1) Type One hospitals.

(a) Effective July 1, 2003, through June 30, 2010, hospital outpatient operating reimbursement shall be at 94.2% of allowable cost and capital reimbursement shall be at 90% of allowable cost.

(b) Effective July 1, 2010, through September 30, 2010, hospital outpatient operating reimbursement shall be at 91.2% of allowable cost and capital reimbursement shall be at 87% of allowable cost.

(c) Effective October 1, 2010, through June 30, 2011, hospital outpatient operating reimbursement shall be at 94.2% of allowable cost and capital reimbursement shall be at 90% of allowable cost.

(d) Effective July 1, 2011, hospital outpatient operating reimbursement shall be at 90.2% of allowable cost and capital reimbursement shall be at 86% of allowable cost.

(2) Type Two hospitals.

(a) Effective July 1, 2003, through June 30, 2010, hospital outpatient operating and capital reimbursement shall be 80% of allowable cost.

(b) Effective July 1, 2010, through September 30, 2010, hospital outpatient operating and capital reimbursement shall be 77% of allowable cost.

(c) Effective October 1, 2010, through June 30, 2011, hospital outpatient operating and capital reimbursement shall be 80% of allowable cost.

(d) Effective July 1, 2011, hospital outpatient operating and capital reimbursement shall be 76% of allowable cost.

d. The last cost report with a fiscal year end on or after December 31, 2013, shall be used for reimbursement for dates of service through December 31, 2013, based on this section. Reimbursement shall be based on charges reported for dates of service prior to January 1, 2014. Settlement will be based on four months of runout from the end of the provider's fiscal year. Claims for services paid after the cost report runout period will not be settled.

e. Payment for direct medical education costs of nursing schools, paramedical programs and graduate medical education for interns and residents.

(1) Direct medical education costs of nursing schools and paramedical programs shall continue to be paid on an allowable cost basis.

(2) Effective with cost reporting periods beginning on or after July 1, 2002, direct graduate medical education (GME) costs for interns and residents shall be reimbursed on a per-resident prospective basis. See 12VAC30-70-281 for prospective payment methodology for graduate medical education for interns and residents.

2. Rehabilitation agencies or comprehensive outpatient rehabilitation.

a. Effective July 1, 2009, rehabilitation agencies or comprehensive outpatient rehabilitation facilities that are operated by community services boards or state agencies shall be reimbursed their costs. For reimbursement methodology applicable to all other rehabilitation agencies, see 12VAC30-80-200.

b. Effective October 1, 2009, rehabilitation agencies or comprehensive outpatient rehabilitation facilities operated by state agencies shall be reimbursed their costs. For reimbursement methodology applicable to all other rehabilitation agencies, see 12VAC30-80-200.

12VAC30-80-36. Fee-for-service providers: outpatient hospitals.

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

"Enhanced ambulatory patient group" or "EAPG" means a defined group of outpatient procedures, encounters, or ancillary services that incorporates International Classification of Diseases (ICD) diagnosis codes, Current Procedural Terminology (CPT) codes, and Healthcare Common Procedure Coding System (HCPCS) codes.

"EAPG relative weight" means the expected average costs for each EAPG divided by the relative expected average costs for visits assigned to all EAPGs.

"Base year" means the state fiscal year for which data is used to establish the EAPG base rate. The base year will change when the EAPG payment system is rebased and recalibrated. In subsequent rebasings, the Commonwealth shall notify affected providers of the base year to be used in this calculation.

"Cost" means the reported cost as described in 12VAC30-80-20 A and B.

"Cost-to-charge ratio" equals the hospital's total costs divided by the hospital's total charges. The Cost-to-charge ratio shall be calculated using data from cost reports from hospital fiscal years ending in the state fiscal year used as the base year.

"Medicare wage index" means the Medicare wage index published annually in the Federal Register by the Centers for Medicare and Medicaid Services. The indices used in this section shall be those in effect in the base year.

B. Effective January 1, 2014, the prospective enhanced ambulatory patient group (EAPG) based payment system described in this subsection shall apply to reimbursement for outpatient hospital services (with the exception of laboratory services referred to the hospital but not associated with an outpatient hospital visit, which will be reimbursed according to the laboratory fee schedule).

1. The payments for outpatient hospital visits shall be determined on the basis of a hospital-specific base rate per visit multiplied by the relative weight of the EAPG (and the payment action) assigned for each of the services performed during a hospital visit.

2. The EAPG relative weights shall be the weights determined and published periodically by DMAS and shall be consistent with applicable Medicaid reimbursement limits and policies. The weights shall be updated at least every three years.

3. The statewide base rate shall be equal to the total costs described in this subdivision divided by the wage-adjusted sum of the EAPG weights for each facility. The wage-adjusted sum of the EAPG weights shall equal the sum of the EAPG weights multiplied by the labor percentage times the hospital's Medicare wage index plus the sum of the EAPG weights multiplied by the nonlabor percentage. The base rate shall be determined for outpatient hospital services at least every three years so that total expenditures will equal the following:

a. When using base years prior to January 1, 2014, for all services, excluding all laboratory services and emergency services described in subdivision 3 c of this subsection, a percentage of costs as reported in the available cost reports for the base period for each type of hospital as defined in 12VAC30-70-221.

(1) Type One hospitals. Effective January 1, 2014, hospital outpatient operating reimbursement shall be calculated at 90.2% of cost, and capital reimbursement shall be at 86% of cost inflated to the rate year.

(2) Type Two hospitals. Effective January 1, 2014, hospital outpatient operating and capital reimbursement shall be calculated at 76% of cost inflated to the rate year.

When using base years after January 1, 2014, the percentages described in subdivision 3 a of this subsection shall be adjusted according to subdivision 3 c of this subsection.

b. Laboratory services, excluding laboratory services referred to the hospital but not associated with a hospital visit, are calculated at the fee schedule in effect for the rate year.

c. Services rendered in emergency departments determined to be nonemergencies as prescribed in 12VAC30-80-20 D 1 b shall be calculated at the nonemergency reduced rate reported in the base year for base years prior to January 1, 2014. For base years after January 1, 2014, the cost percentages in subdivision 3 a of this subsection shall be adjusted to reflect services paid at the nonemergency reduced rate in the last base year prior to January 1, 2014.

4. Inflation adjustment to base year costs. Each July, the Virginia moving average values as compiled and published by Global Insight (or its successor), under contract with DMAS, shall be used to update the base year costs to the midpoint of the rate year. The most current table available prior to the effective date of the new rates shall be used to inflate base year amounts to the upcoming rate year. Thus, corrections made by Global Insight (or its successor) in the moving averages that were used to update rates for previous state fiscal years shall be automatically incorporated into the moving averages that are being used to update rates for the upcoming state fiscal year. Inflation shall be applied to the costs identified in subdivision 3 a of this subsection.

5. Hospital-specific base rate. The hospital-specific base rate per case shall be adjusted for geographic variation. The hospital-specific base rate shall be equal to the labor portion of the statewide base rate multiplied by the hospital's Medicare wage index plus the nonlabor percentage of the statewide base rate. The labor percentage shall be determined at each rebasing based on the most recently reliable data. For rural hospitals, the hospital's Medicare wage index used to calculate the base rate shall be the Medicare wage index of the nearest metropolitan wage area or the effective Medicare wage index, whichever is higher. A base rate differential of 5.0% shall be established for freestanding Type Two children's hospitals. The base rate for noncost-reporting hospitals shall be the average of the hospital-specific base rates of in-state Type Two hospitals.

6. The total payment shall represent the total allowable amount for a visit including ancillary services and capital.

7. The transition from cost-based reimbursement to EAPG reimbursement shall be transitioned over a four-year period. DMAS shall calculate a cost-based base rate at January 1, 2014, and at each rebasing during the transition.

a. Effective for dates of service on or after January 1, 2014, DMAS shall calculate the hospital-specific base rate as the sum of 75% of the cost-based base rate and 25% of the EAPG base rate.

b. Effective for dates of service on or after July 1, 2014, DMAS shall calculate the hospital-specific base rate as the sum of 50% of the cost-based base rate and 50% of the EAPG base rate.

c. Effective for dates of service on or after July 1, 2015, DMAS shall calculate the hospital-specific base rate as the sum of 25% of the cost-based base rate and 75% of the EAPG base rate.

d. Effective for dates of service on or after July 1, 2016, DMAS shall calculate the hospital-specific base rate as the EAPG base rate.

8. To maintain budget neutrality during the first six years of the transition to EAPG reimbursement, DMAS shall compare the total reimbursement of hospital claims based on the parameters in subdivision 3 of this subsection to EAPG reimbursement every six months based on the six months of claims ending three months prior to the potential adjustment. If the percentage difference between the reimbursement target in subdivision 3 of this subsection and EAPG reimbursement is greater than 1.0%, plus or minus, DMAS shall adjust the statewide base rate by the percentage difference the following July 1 or January 1. The first possible adjustment would be January 1, 2015, using reimbursement between January 1, 2014, and October 31, 2014.

C. The enhanced ambulatory patient group (EAPG) grouper version used for outpatient hospital services shall be determined by DMAS. Providers or provider representatives shall be given notice prior to implementing a new grouper.

D. The primary data sources used in the development of the EAPG payment methodology are the DMAS hospital computerized claims history file and the cost report file. The claims history file captures available claims data from all enrolled, cost-reporting general acute care hospitals. The cost report file captures audited cost and charge data from all enrolled general acute care hospitals. The following table identifies key data elements that are used to develop the EAPG payment methodology. DMAS may supplement this data with similar data for Medicaid services furnished by managed care organizations if DMAS determines that it is reliable.

Data Elements for EAPG Payment Methodology	
Data Elements	Source
Total charges for each outpatient hospital visit	Claims history file
Number of groupable claims lines in each EAPG	Claims history file
Total number of groupable claim lines	Claims history file
Total charges for each outpatient hospital revenue line	Claims history file

Total number of EAPG assignments	Claims history file
Cost-to-charge ratio for each hospital	Cost report file
Medicare wage index for each hospital	Federal Register

12VAC30-80-40. Fee-for-service providers: pharmacy.

Payment for pharmacy services (excluding outpatient hospital) shall be the lowest of subdivisions 1 through 5 of this section (except that subdivisions 1 and 2 of this section will not apply when prescriptions are certified as brand necessary by the prescribing physician in accordance with the procedures set forth in 42 CFR 447.512(c) if the brand cost is greater than the Centers for Medicare and Medicaid Services (CMS) upper limit of VMAC cost) subject to the conditions, where applicable, set forth in subdivisions 6 and 7 of this section:

1. The upper limit established by the CMS for multiple source drugs pursuant to 42 CFR 447.512 and 447.514, as determined by the CMS Upper Limit List plus a dispensing fee. If the agency provides payment for any drugs on the HCFA Upper Limit List, the payment shall be subject to the aggregate upper limit payment test.

2. The methodology used to reimburse for generic drug products shall be the higher of either (i) the lowest Wholesale Acquisition Cost (WAC) plus 10% or (ii) the second lowest WAC plus 6.0%. This methodology shall reimburse for products' costs based on a Maximum Allowable Cost (VMAC) list to be established by the single state agency.

a. In developing the maximum allowable reimbursement rate for generic pharmaceuticals, the department or its designated contractor shall:

(1) Identify three different suppliers, including manufacturers that are able to supply pharmaceutical products in sufficient quantities. The drugs considered must be listed as therapeutically and pharmaceutically equivalent in the Food and Drug Administration's most recent version of the Approved Drug Products with Therapeutic Equivalence Evaluations (Orange Book). Pharmaceutical products that are not available from three different suppliers, including manufacturers, shall not be subject to the VMAC list.

(2) Identify that the use of a VMAC rate is lower than the Federal Upper Limit (FUL) for the drug. The FUL is a known, widely published price provided by CMS; and

(3) Distribute the list of state VMAC rates to pharmacy providers in a timely manner prior to the implementation of VMAC rates and subsequent modifications. DMAS shall publish on its website, each month, the information used to set the Commonwealth's prospective VMAC rates, including, but not necessarily limited to:

(a) The identity of applicable reference products used to set the VMAC rates;

(b) The Generic Code Number (GCN) or National Drug Code (NDC), as may be appropriate, of reference products;

(c) The difference by which the VMAC rate exceeds the appropriate WAC price; and

(d) The identity and date of the published compendia used to determine reference products and set the VMAC rate. The difference by which the VMAC rate exceeds the appropriate WAC price shall be at least or equal to 10% above the lowest-published wholesale acquisition cost for products widely available for purchase in the Commonwealth and shall be included in national pricing compendia.

b. Development of a VMAC rate that does not have a FUL rate shall not result in the use of higher-cost innovator brand name or single source drugs in the Medicaid program.

c. DMAS or its designated contractor shall:

(1) Implement and maintain a procedure to add or eliminate products from the list, or modify VMAC rates, consistent with changes in the fluctuating marketplace. DMAS or its designated contractor will regularly review manufacturers' pricing and monitor drug availability in the marketplace to determine the inclusion or exclusion of drugs on the VMAC list; and

(2) Provide a pricing dispute resolution procedure to allow a dispensing provider to contest a listed VMAC rate. DMAS or its designated contractor shall confirm receipt of pricing disputes within 24 hours, via telephone or facsimile, with the appropriate documentation of relevant information, ~~e.g.~~ for example, invoices. Disputes shall be resolved within three business days of confirmation. The pricing dispute resolution process will include DMAS' or the contractor's verification of accurate pricing to ensure consistency with marketplace pricing and drug availability. Providers will be reimbursed, as appropriate, based on findings. Providers shall be required to use this dispute resolution process prior to exercising any applicable appeal rights.

3. The provider's usual and customary charge to the public, as identified by the claim charge.

4. The Estimated Acquisition Cost (EAC), which shall be based on the published Average Wholesale Price (AWP) minus a percentage discount established by the General Assembly (as set forth in subdivision 7 of this section) or, in the absence thereof, by the following methodology set out in subdivisions a through c of this subdivision.

a. Percentage discount shall be determined by a statewide survey of providers' acquisition cost.

b. The survey shall reflect statistical analysis of actual provider purchase invoices.

c. The agency will conduct surveys at intervals deemed necessary by DMAS.

5. MAC methodology for specialty drugs. Payment for drug products designated by DMAS as specialty drugs shall be the lesser of subdivisions 1 through 4 of this section or the following method, whichever is least:

a. The methodology used to reimburse for designated specialty drug products shall be the WAC price plus the WAC percentage. The WAC percentage is a constant percentage identified each year for all GCNs.

b. Designated specialty drug products are certain products used to treat chronic, high-cost, or rare diseases; the drugs subject to this pricing methodology and their current reimbursement rates are listed on the DMAS website at the following internet address: ~~http://www.dmas.virginia.gov/downloads/pdfs/pharm-special_mac_list.pdf~~ http://www.dmas.virginia.gov/Content_pgs/pharm-home.aspx.

c. The MAC reimbursement methodology for specialty drugs shall be subject to the pricing review and dispute resolution procedures described in subdivisions 2 c (1) and 2 c (2) of this section.

6. Payment for pharmacy services will be as described ~~above~~ in subdivisions 1 through 5 of this section; however, payment for legend drugs will include the allowed cost of the drug plus only one dispensing fee per month for each specific drug. Exceptions to the monthly dispensing fees shall be allowed for drugs determined by the department to have unique dispensing requirements. The dispensing fee for brand name and generic drugs is $3.75.

7. An EAC of AWP minus 13.1% shall become effective July 1, 2011. The dispensing fee for brand name and generic drugs of $3.75 shall remain in effect, creating a payment methodology based on the previous algorithm (least of subdivisions of this section) plus a dispensing fee where applicable.

8. Home infusion therapy.

a. The following therapy categories shall have a pharmacy service day rate payment allowable: hydration therapy, chemotherapy, pain management therapy, drug therapy, and total parenteral nutrition (TPN). The service day rate payment for the pharmacy component shall apply to the basic components and services intrinsic to the therapy category. Submission of claims for the per diem rate shall be accomplished by use of the CMS 1500 claim form.

b. The cost of the active ingredient or ingredients for chemotherapy, pain management, and drug therapies shall be submitted as a separate claim through the pharmacy program, using standard pharmacy format. Payment for this component shall be consistent with the current reimbursement for pharmacy services. Multiple applications of the same therapy shall be reimbursed one service day rate for the pharmacy services. Multiple applications of different therapies shall be reimbursed at 100% of standard pharmacy reimbursement for each active ingredient.

9. Supplemental rebate agreement. The Commonwealth complies with the requirements of § 1927 of the Social Security Act and Subpart I (42 CFR 447.500 et seq.) of 42 CFR Part 447 with regard to supplemental drug rebates. In addition, the following requirements are also met:

a. Supplemental drug rebates received by the state in excess of those required under the national drug rebate agreement will be shared with the federal government on the same percentage basis as applied under the national drug rebate agreement.

b. Prior authorization requirements found in § 1927(d)(5) of the Social Security Act have been met.

c. Nonpreferred drugs are those that were reviewed by the Pharmacy and Therapeutics Committee and not included on the preferred drug list. Nonpreferred drugs will be made available to Medicaid beneficiaries through prior authorization.

d. Payment of supplemental rebates may result in a product's inclusion on the PDL.

10. Each drug administered in an outpatient hospital setting and reimbursed based on the enhanced ambulatory patient group methodology, as described in 12VAC30-80-36, shall be reimbursed separately at a rate greater than zero to be eligible for drug rebate claiming.

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Fast-Track Regulation

Title of Regulation: **12VAC30-95. Standards Established and Methods Used for Fee-for-Service Reimbursement (amending 12VAC30-95-5; adding 12VAC30-95-10).**

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: January 28, 2015.

Effective Date: February 13, 2015.

Agency Contact: Brian McCormick, Regulatory Supervisor, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-8856, FAX (804) 786-1680, TTY (800) 343-0634, or email brian.mccormick@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 Plan for Medical Assistance. Sections 32.1-324 and 32.1-325 of the Code of Virginia authorize the Director of the Department of Medical Assistance Services (DMAS) to administer and amend the Plan for Medical Assistance according to the board's

requirements. The Medicaid authority as established by § 1902 (a) of the Social Security Act (42 USC § 1396a) provides governing authority for payments for services.

Section 1902(a)(37) of the Social Security Act (the Act) and 42 CFR 447.45 set out federal requirements, applicable to all Medicaid programs, for the timely payment of providers' claims. All Medicaid programs must require providers to submit their claims for payment within 12 months of the date when the service was rendered as well as process clean claims for payment within certain time standards.

Purpose: The purpose of this action is to establish in regulation a set deadline for the resubmission of originally denied claims for reimbursement. This action is created in a chapter of the Virginia Administrative Code titled "Standards Established and Methods Used for Fee-for-Service Reimbursement" in which DMAS intends to place new regulations addressing often frequently contested provider reimbursement issues, such as the use of electronic signatures and electronic medical records. This action has no effect on the health, safety, or welfare of Medicaid individuals or citizens of the Commonwealth. This action is strictly administrative in nature and will enable DMAS and enrolled providers to maintain their accounts as current.

Rationale for Using Fast-Track Process: DMAS believes that the fast-track rulemaking process is the most efficient process for creating a final regulation with public input. DMAS does not anticipate any negative response to this action as it is expected to create greater stability and predictability for providers in managing their reimbursement funding and accounts with DMAS.

Substance: Currently, DMAS administers its federally required claims processing system consistent with § 1902(a)(37) of the Act and 42 CFR 447.45. This action does not propose to change any of these ongoing policies and procedures as the federal requirements do not permit it. This action proposes to set standards for the filing of providers' claims that were initially denied.

In SFY 2011, DMAS' monthly average number of all claim types (paper, electronic, point-of-sale, and encounters) was 4.8 million claims; in SFY 2012, this average was 4.8 million; and in SFY 2013, this average was 5.5 million.

The current claims processing system, upon being presented with a claim, verifies (i) the current eligibility of the Medicaid individual and the service provider; (ii) the provider's eligibility to perform the service (a podiatrist is not allowed to perform brain surgery, for example); (iii) the service does not exceed the agency's service limits and the service is logical for the individual's characteristics (a claim for a man's delivery of a baby, for example, would not be paid); (iv) the claim is not a duplicate nor does it conflict with one currently being processed for payment; and (v) the prior authorization documentation of the service if the agency requires it. Fee-for-service providers are allowed up to 12 months from the date that a service is rendered during which to submit their original claims for payment to DMAS. Claims that pass these initial checks are deemed to be "clean."

DMAS receives providers' claims in various forms and pays the following amounts to its claims processing fiscal agent to process them: paper claims (48¢), electronic claims (20¢), point-of-sale claims (21¢), and encounters (18¢). Most providers use electronic claims filing (FY 2011 93.8%, FY 2012 95.1%, FY 2013 97.7%). Point-of-sale claims are submitted by pharmacies. Encounter claims are submitted by managed care organizations, Logisticare (transportation claims), and DentaQuest (dental claims). As of FY 2013, a claims processing report showed the following average days to process the claims and average days to writing the providers' checks:

Type of Provider	Average Days to Process	Average Days to Write Check
Inpatient Hospital	8	17
Outpatient Hospital	11	21
Nursing Home	4	12
Practitioner	3	12
Transportation	1	10

Claims failing the standard "clean claim" checks are denied. Such denial notices are returned to the billing providers in their weekly remittance vouchers, which set out the reason for the denial. At this time, providers are expected to review their remittances and seek to make timely corrections of the errors (technical corrections of invalid identification numbers or invalid procedure code numbers, for example, or supplying background documentation, such as prior authorization documentation) in their claims. Such corrected claims are then resubmitted to DMAS for processing.

All providers do not do this, however. In the recent past, DMAS has experienced an increasing number of previously denied claim resubmissions, some as old as five years, from a variety of provider types. The following lists the types of provider that have been resubmitting very old claims for reconsideration and the amounts that DMAS has paid in SFY 2013:

Inpatient Hospitals	$15,924,817
Outpatient Hospitals	$1,669,613
Personal Care	$34,309
Practitioner	$1,574,625
Independent Laboratories	$94,347
Cross Over Claims (XVIII)	$309,009
Skilled Nursing Facility	$3,922
Transportation	$5,042

Practitioner (almost 50%) and Cross Over (Title XVIII) (33%) represent the two largest percentages of resubmitted previously denied claims. Inpatient/outpatient hospitals' resubmissions result in the largest expenditures ($15.9 million and $1.6 million, respectively) because these two services represent the highest cost services.

Currently, DMAS has no regulatory time limits for providers to resubmit previously denied claims. Some providers have resubmitted claims for dates of services as old as five years after the original claim. Also, some providers have resubmitted (multiple times) claims that have already been denied. DMAS has observed an increase in this activity over the last several years. DMAS is proposing to allow providers up to an additional 13 months, from the initial denial date of the original claim, to resubmit claims that have been corrected or supply additional documentation for DMAS reconsideration. By establishing a 13-month deadline for the resubmission of previously denied claims, DMAS is maximizing flexibility for providers while implementing a process to set reasonable limits on open provider accounts. Revised (previously denied) claims that are resubmitted later than the suggested time frame will be denied.

DMAS is providing for two exceptions, as set out in 12VAC30-95-10 E, to this new limitation: (i) if a provider's claim was retracted by a third party payer, DMAS will consider the date of the retraction notice by the third party payer as the beginning date of the initial 12-month timely filing period and (ii) in situations of retroactive eligibility, DMAS will consider the date of the notification of delayed eligibility from the local department of social services as the beginning date of the initial 12-month timely filing period. Both of these situations are outside of the fee-for-service providers' abilities to control so that to refuse payment of such claims would be inappropriate.

Issues: The primary advantage of this action to DMAS and Medicaid fee-for-service providers is that it creates a predictable deadline for both DMAS and Medicaid fee-for-service providers in which both entities can finally and fully close out open accounts. This enhances the ability of providers and DMAS to efficiently administer their funds and accounts.

Fee-for-service providers that are in the habit of delaying their remittance reconciliations for years on end are not expected to agree with this regulation. Providers who have the practice of repeatedly resubmitting previously denied claims in hopes of finally being paid are also not expected to agree with this regulation. Pharmacies and managed care organizations will not be affected by this action because they use, respectively, point-of-sale claim submission and encounter claims. All fee-for-service providers will be affected by this proposal.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The proposed regulation 1) establishes a 13-month deadline in which Medicaid providers may resubmit previously denied claims for reconsideration by the Department of Medical Assistance Services (DMAS), and 2) incorporates the federally mandated 12-month time period (from the date of service) for providers to submit their original claims for services rendered.

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

Estimated Economic Impact. The proposed regulation establishes a 13-month deadline in which Medicaid providers may resubmit previously denied claims for reconsideration. Currently, there is no regulatory time limit for providers to resubmit previously denied claims.

Fee-for-service providers are allowed up to 12 months from the date that a service is rendered in which to submit their original claims for payment. Upon being presented with a claim, DMAS performs several checks including verification of Medicaid eligibility of the individual and the service provider; provider's eligibility to perform the service (a podiatrist is not allowed perform brain surgery, for example); compliance with service limits and consistency with the individual's characteristics (a claim for a man's delivery of a baby, for example, would not be paid); whether the claim is a duplicate or conflicts with one currently being processed for payment; and compliance with the prior authorization of the service if it is required.

Claims that pass these initial checks are deemed to be "clean." Claims failing the initial checks are denied. Such denial notices are returned to the billing providers in their weekly remittance vouchers, which set out the reason for the denial. According to DMAS, some providers have re-submitted claims for dates of services as old as five years after the original claim. Also, some providers have re-submitted claims which have already been denied multiple times. DMAS reports an increase in this activity over the last several years.

In fiscal year 2013, DMAS has paid $15.9 million to inpatient hospitals, $1.7 million to outpatient hospitals, $1.6 million to practitioners, $309,009 to cross over providers, $94,347 to independent laboratories, $34,309 to personal care providers, $5,042 to transportation providers, and $3,922 to skilled nursing facilities for the claims that were resubmitted.

Having no deadline in claim resubmission has the effect of both DMAS and providers dealing with open accounts sometimes for years at a time. The proposed regulation introduces a 13-month deadline in which Medicaid providers may resubmit previously denied claims for reconsideration. The proposed time limit appears to be reasonable when compared to private industry practices. DMAS reports that some health insurance entities allow only a single 12-month period for providers to submit their claims with re-

submissions not permitted. Some other entities are reported to allow only 180 days for providers to submit their claims.

The proposed 13-month time limit is expected to bring closure to old accounts. With the proposed time limit, providers will have incentives to resubmit failed claims within the 13-month window and do a better job in addressing the reason for the original denial. Thus, providers are expected to dedicate more resources to the denied claims within the proposed 13-month time frame which would force DMAS to do the same. Also, since this action will bring an end to the denied claims that would have been resubmitted multiple times, DMAS and providers are likely to realize some administrative savings. Finally, the proposed time limit may reduce a provider's chance of recovering a denied claim and may have a negative impact on their revenues while reducing the Medicaid expenditures at the same time.

The proposed regulation also incorporates the federally mandated 12-month time period (from the date of service) for providers to submit their original claims for services rendered. This policy has already been enforced in practice. Thus no significant effect is expected from this change other than improving the clarity of the regulations.

Businesses and Entities Affected. The proposed claim resubmission time frame applies to 118,437 fee-for-service providers currently enrolled.

Localities Particularly Affected. The regulation applies throughout the Commonwealth.

Projected Impact on Employment. Affected providers are expected to dedicate more resources to the denied claims within the proposed 13-month time frame which would force DMAS to do the same. So, an increase in demand for labor within the 13-month time frame to resubmit and process denied claims may be expected. However, providers may reduce their demand for labor after the 13-month time frame as they will no longer be able to resubmit claims.

Effects on the Use and Value of Private Property. To the extent the proposed claim resubmission time limit reduces the recovery of revenues from previously denied claims, providers may see a negative impact on their profits and consequently on their asset values. On the other hand, expected administrative savings from no longer dealing with old accounts will likely provide some administrative savings and offset some of the expected revenue losses and negative impact on asset values.

Small Businesses: Costs and Other Effects. The proposed time limits apply to 118,437 fee-for-service providers most of which are small businesses. The costs and other affects on affected entities are same as discussed above.

Small Businesses: Alternative Method that Minimizes Adverse Impact. There is no known alternative method that minimizes adverse impact while accomplishing the same goals.

Real Estate Development Costs. The proposed amendments are unlikely to affect real estate development costs.

Legal Mandate.

General: The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007.04 of the Code of Virginia and Executive Order Number 14 (2010). Section 2.2-4007.04 requires that such economic impact analyses determine the public benefits and costs of the proposed amendments. Further the report should include but not be limited to:

- the projected number of businesses or other entities to whom the proposed regulation would apply,
- the identity of any localities and types of businesses or other entities particularly affected,
- the projected number of persons and employment positions to be affected,
- the projected costs to affected businesses or entities to implement or comply with the regulation, and
- the impact on the use and value of private property.

Small Businesses: If the proposed regulation will have an adverse effect on small businesses, § 2.2-4007.04 requires that such economic impact analyses include:

- an identification and estimate of the number of small businesses subject to the proposed regulation,
- the projected reporting, recordkeeping, and other administrative costs required for small businesses to comply with the proposed regulation, including the type of professional skills necessary for preparing required reports and other documents,
- a statement of the probable effect of the proposed regulation on affected small businesses, and
- a description of any less intrusive or less costly alternative methods of achieving the purpose of the proposed regulation.

Additionally, pursuant to § 2.2-4007.1, if there is a finding that a proposed regulation may have an adverse impact on small business, the Joint Commission on Administrative Rules (JCAR) is notified at the time the proposed regulation is submitted to the Virginia Register of Regulations for publication. This analysis shall represent DPB's best estimate for the purposes of public review and comment on the proposed regulation.

Agency's Response to Economic Impact Analysis: The agency has reviewed the economic impact analysis prepared by the Department of Planning and Budget regarding Standards Established and Methods Used for Fee-for-Service Reimbursement (12VAC30-95). The agency concurs with this analysis.

Summary:

This regulation (i) establishes a 13-month deadline in which Medicaid providers may resubmit previously denied

claims for reconsideration by the Department of Medical Assistance Services and (ii) incorporates the federally mandated 12-month time period from the date of service for providers to submit their original claims for services rendered.

12VAC30-95-5. ~~General~~ Applicability; general definitions.

A. The requirements of this chapter shall operate in addition to the provider requirements set out in other chapters of the Virginia Administrative Code, including but not limited to 12VAC30-50 through 12VAC30-90.

B. The following words and terms when used in 12VAC30 shall have the following meanings unless the context clearly indicates otherwise:

"ASAM" means the American Society of Addiction Medicine.

"ICD" means (i) for claims with dates of service on or prior to September 30, 2015, the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) Volumes 1, 2, and 3, OptumInsight, Inc., and (ii) for claims with dates of service on or after October 1, 2015, the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) and Procedure Coding System (ICD-10-PCS) pursuant to 45 CFR 162.1002, OptumInsight, Inc.

12VAC30-95-10. Timely claims filing.

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

"Claim" means the term as defined in 42 CFR 447.45 and includes a bill or a line item for services, drugs, or devices.

"Submit" or "file" means actual, physical receipt by the Department of Medical Assistance Services (DMAS) that is documented in DMAS records.

B. Consistent with 42 CFR 447.45, providers shall submit all claims to DMAS no later than 12 months from the date of service for which the provider requests reimbursement. In the absence of the two exception conditions set out in subsection E of this section, all claims otherwise submitted to DMAS after this 12-month time limit shall be denied.

C. In cases where the actual receipt of a claim by DMAS is undocumented, the burden of proof shall be on the provider to show that the claim was actually, physically received by DMAS. Proof by the provider that a claim was mailed, transmitted, or conveyed to DMAS by any method shall not constitute proof of receipt. The provider shall confirm actual receipt of a claim by DMAS within 12 months from the date of the service reflected on a claim.

D. If a claim for payment under Medicare has been filed in a timely manner, DMAS may pay a Medicaid claim for the same service within six months after the provider receives notice of the disposition of the Medicare claim.

E. Exceptions.

1. For cases in which a provider's claim was retracted by the third party payer, DMAS shall consider the date of the retraction notice by the third party payer as the begin date of the initial 12-month timely filing period.

2. For cases of retroactive Medicaid eligibility, DMAS shall consider the date of the notification of delayed eligibility from the local department of social services as the begin date of the initial 12-month timely filing period.

F. If DMAS denies a provider's original claim for reimbursement, the provider may resubmit the claim for reconsideration, together with any and all documentation to support the previously denied claim. All supporting documentation shall be filed at the time of the claim resubmission. DMAS shall not reconsider any resubmitted claim where:

1. The previously denied claim was not originally submitted within 12 months of the date of service, or

2. The denied claim was not resubmitted to DMAS within 13 months of the date the original claim was initially denied.

G. Once DMAS determines that a resubmitted claim cannot be paid and takes a denial action, it shall not be submitted again.

VA.R. Doc. No. R15-3170; Filed December 10, 2014, 11:13 a.m.

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

Emergency Regulation

Title of Regulation: **12VAC35-225. Requirements for Virginia Early Intervention System (adding 12VAC35-225-10 through 12VAC35-225-540).**

Statutory Authority: § 2.2-5304 of the Code of Virginia; 34 CFR Part 303.

Effective Dates: December 15, 2014, through June 14, 2016.

Agency Contact: Catherine Hancock, Part C Administrator, Department of Behavioral Health and Developmental Services, 1220 Bank Street, Richmond, VA 23218, telephone (804) 371-6592, FAX (804) 371-7959, or email catherine.hancock@dbhds.virginia.gov.

Preamble:

Item 315 H 4 of Chapter 806 of the 2013 Acts of Assembly requires the Department of Behavioral Health and Developmental Services to promulgate emergency regulations to provide requirements for Virginia's early intervention services and supports system for children and their families under the federal Part C program. Infants and toddlers from birth through age two years who are not developing as expected or who have a medical condition that can delay normal development may require early intervention supports and services. The Virginia statewide system of early intervention services, the Infant & Toddler Connection of Virginia, has been operating since the mid-

1980s to identify children who could benefit from early intervention services, establish their eligibility under Part C of the Individuals with Disabilities Education Act (IDEA), coordinate care, and assure the availability of needed services. Last year 15,523 infants and toddlers were served in this system. More than 190 provider agencies participated in Virginia's early intervention system and 888 individuals were certified as early intervention practitioners. This regulatory action codifies those portions of Virginia's current policies, procedures, and practices that require the force of law to successfully enforce and to ensure that the state remains in compliance with federal mandates.

These regulations (i) provide details regarding the state infrastructure for early intervention services, not already provided by the Code of Virginia; (ii) clarify Virginia's referral system; (iii) outline the intake, eligibility determination, and assessment processes; (iv) detail the expectations regarding service planning and delivery, including transition or discharge from the early intervention system of care; (v) explain the service funding and payment expectations; (vi) establish the procedural safeguards that individuals can expect; (vii) address the alternative to resolve disputes; and (viii) establish a certification process for certain early intervention practitioners and a comprehensive system of personnel development.

CHAPTER 225
REQUIREMENTS FOR VIRGINIA EARLY INTERVENTION SYSTEM

Part I
Authority and Definitions

12VAC35-225-10. Authority.

A. Pursuant to § 2.2-5304 of the Code of Virginia, the Governor has designated the Department of Behavioral Health and Developmental Services as the state lead agency responsible for implementing the Virginia early intervention services system and ensuring compliance with federal requirements.

B. Sections 2.2-2664, 2.2-5301, 2.2-5303, 2.2-5304, 2.2-5305, and 2.2-5306 of the Code of Virginia establish the structure of Virginia's early intervention system, including the duties and responsibilities of the state lead agency, coordinating council, and participating agencies.

C. Virginia's early intervention system, the Infant & Toddler Connection of Virginia, must include, at a minimum, the components required by Part C of the Individuals with Disabilities Education Act at 20 USC § 1435(a) and at 34 CFR Part 303.

12VAC35-225-20. Definitions.

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

"Ability to pay" means the amount a family is able to contribute toward the cost of early intervention services, based on family size, income, and expenses.

"Adjusted age" means an adjustment that is made for premature birth (gestation < 37 weeks) used to determine developmental status until the child is 18 months old.

"Administrative complaint" means a written, signed complaint by an individual or organization alleging that the department, local lead agency, or early intervention service provider violated a requirement of Part C or 12VAC35-225.

"Assessment" means the ongoing procedures used by qualified early intervention service providers to identify (i) the child's unique strengths and needs and the concerns of the family; (ii) the early intervention services appropriate to meet those needs throughout the period of the child's eligibility under Part C; and (iii) the resources, priorities, and supports and services necessary to enhance the family's capacity to meet the developmental needs of the child.

"Assistive technology device" means any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, fabricated, or customized, that is used to increase, maintain, or improve functional capabilities of a child. The term does not include a medical device that is surgically implanted, such as a cochlear implant, or the optimization (e.g., mapping), maintenance, or replacement of that device.

"Assistive technology service" means any service that directly assists in the selection, acquisition, or use of an assistive technology device. Assistive technology services include (i) evaluating the needs of the child, including a functional evaluation in the child's customary environment; (ii) purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices; (iii) selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices; (iv) coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing education and rehabilitation plans and programs; (v) providing training or technical assistance to a child, or, if appropriate, that child's family; and (vi) providing training or technical assistance to professionals (including individuals providing education or rehabilitation services) or other individuals who provide services to or are otherwise substantially involved in the major life functions of the child.

"Atypical development" means one or more of the following conditions or responses: (i) atypical or questionable sensory-motor responses; (ii) atypical or questionable social-emotional development; (iii) atypical or questionable behaviors that interfere with the acquisition of developmental skills; or (iv) impaired social interaction and communication skills with restricted and repetitive behaviors.

"Audiology" means services that include (i) identifying children with auditory impairments, using at risk criteria and

appropriate audiologic screening techniques; (ii) determining the range, nature, and degree of hearing loss and communication functions by use of audiological evaluation procedures; (iii) referring children with auditory impairment for medical or other services necessary for habilitation or rehabilitation; (iv) providing auditory training, aural rehabilitation, speech reading and listening devices, orientation and training, and other services; (v) providing services for prevention of hearing loss; and (vi) determining the child's individual amplification, including selecting, fitting, and dispensing appropriate listening and vibrotactile devices, and evaluating the effectiveness of those devices.

"Child find" means a comprehensive and coordinated system to locate, identify, refer, and evaluate all children with disabilities in Virginia who may be eligible for early intervention services under Part C.

"Child with a disability" or "infant or toddler with a disability" means an individual who is under three years of age and who needs early intervention services because he is experiencing a developmental delay in one or more areas of development or atypical development or has a diagnosed physical or mental condition that has a high probability of resulting in developmental delay.

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

"Counseling services" means the assessment and treatment of mental, emotional, or behavioral disorders and associated distresses that interfere with mental health, including (i) individual and/or family group counseling with the parent or parents and other family members; (ii) collaborating with the family, service coordinator, and other early intervention service providers identified on an infant's or toddler's individualized family service plan (IFSP); and (iii) family training, education, and support provided to assist the family of an infant or toddler with a disability in understanding his needs related to development, behavior or social-emotional functioning and to enhance his development.

"Day" means calendar day, unless clearly specified otherwise.

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

"Developmental delay" means a level of functioning that (i) is at least 25% below the child's chronological or adjusted age in cognitive, physical, communication, social or emotional, or adaptive development or (ii) demonstrates atypical development or behavior even in the absence of a 25% delay. Developmental delay is measured using the evaluation and assessment procedures described in 12VAC35-225-90.

"Developmental services" means services provided to a child with a disability that include (i) designing learning environments and activities that promote the child's acquisition of skills in a variety of developmental areas, including cognitive processes and social interaction; (ii) curriculum planning, including the planned interaction of personnel, materials, time, and space, that leads to achieving the outcomes in the child's IFSP; (iii) providing families with information, skills, and support related to enhancing the skill development of the child; and (iv) working with the child to enhance his development.

"Discipline" or "profession" means a specific occupational category that may provide early intervention supports and services to eligible children under Part C and their families.

"Due process complaint" means a complaint filed by a parent requesting a due process hearing to resolve a disagreement with an early intervention service provider's proposal or refusal to initiate or change identification, eligibility determination, or placement of the child or the provision of early intervention services to the child or family.

"Duration" means the projection of when a given early intervention service will no longer be provided (such as when the child is expected to achieve the results or outcomes in his IFSP).

"Early intervention practitioner" means a person who is qualified to apply for or who holds certification as an early intervention professional, specialist, or case manager. An early intervention practitioner may be employed as an early intervention service provider under Part C.

"Early intervention service provider" means a provider agency (whether public, private, or nonprofit) or an early intervention practitioner that provides early intervention services under Part C, whether or not the agency or individual receives federal Part C funds.

"Early intervention records" means all records regarding a child that are required to be collected, maintained, or used under Part C.

"Early intervention services" means services provided through Part C designed to meet the developmental needs of children and families and to enhance the development of children from birth to age three years who have (i) a 25% developmental delay in one or more areas of development, (ii) atypical development, or (iii) a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay. Early intervention services provided in the child's home and in accordance with this chapter shall not be construed to be home health services as referenced in § 32.1-162.7 of the Code of Virginia.

"Eligibility determination" means the evaluation procedures used by qualified early intervention service providers to determine a child's initial and continuing eligibility under Part C.

"Family fee" means the amount based on the accrued charges and copayments that may be charged to families for services that an infant or toddler with a disability and family receive each month. The family fee may not exceed the monthly cap.

"Frequency" means the number of days or sessions a service will be provided.

"Health services" means services necessary to enable a child receiving services under Part C to benefit from other early intervention supports and services he receives and includes (i) providing clean intermittent catheterization, tracheostomy care, tube feeding, the changing of dressings or colostomy collection bags, and other health services and (ii) arranging consultation by physicians with other service providers concerning the special health care needs of the child that will need to be addressed in the course of providing other early intervention services. The term does not include services that are surgical in nature (such as cleft palate surgery, surgery for club foot, or the shunting of hydrocephalus); purely medical in nature (such as hospitalization for management of congenital heart ailments or the prescribing of medicine or drugs for any purpose); or related to the implementation, optimization (e.g., mapping), maintenance, or replacement of a medical device that is surgically implanted, including a cochlear implant; devices (such as heart monitors, respirators and oxygen, and gastrointestinal feeding tubes and pumps) necessary to control or treat a medical condition; or medical health services (such as immunizations and regular "well-baby" care) that are routinely recommended for all children.

"Homeless children" means children who meet the definition given the term homeless children and youths in § 752 (42 USC § 11434a) of the McKinney-Vento Homeless Assistance Act, as amended, 42 USC § 11434a et seq.

"Inability to pay" means the amount a family is able to contribute toward the cost of early intervention services is zero, resulting in the family's receiving all early intervention services at no cost to the family.

"Indian" means an individual who is a member of an Indian tribe.

"Indian tribe" means any federal or state Indian tribe, band, rancheria, pueblo, colony, or community, including any Alaska native village or regional village corporation.

"Individualized family service plan" or "IFSP" means a written plan for providing early intervention supports and services to a child with a disability or his family that (i) is based on the evaluation for eligibility determination and assessment for service planning; (ii) includes information based on the child's evaluation and assessments, family information, results or outcomes, and supports and services based on peer-reviewed research (to the extent practicable) that are necessary to meet the unique needs of the child and the family and to achieve the results or outcomes; and (iii) is implemented as soon as possible once parental consent is obtained.

"Informed clinical opinion" means the use of professional expertise and experience in combination with information gathered through eligibility determination or assessment for service planning, or both, to determine the child's developmental status and eligibility under Part C.

"Initial early intervention service coordination plan" means a written plan that specifies the activities that will be completed by the service coordinator prior to completion of the individualized family service plan.

"Intensity" means whether a service will be provided on an individual or group basis.

"Length of service" means the amount of time the service will be provided during each session (such as an hour or other specified timeframe).

"Local lead agency" means an entity that, under contract with the department, administers a local early intervention system.

"Location of service" means the actual place or places where the early intervention service will be provided.

"Medical services" means services provided by a licensed physician for diagnostic or eligibility determination purposes to determine a child's developmental status and need for early intervention supports and services.

"Monthly cap" means the maximum amount that a family will be required to pay per month for early intervention services regardless of the charge or charges or number of different types, frequency, or length of services a child and family receive.

"Multidisciplinary" means the involvement of two or more separate disciplines or professions.

"Native language" means the language or mode of communication (such as sign language, Braille, or oral communication for persons with no written language) that is normally used by the child or his parents.

"Natural environments" means settings that are natural or typical for a same-aged child without a disability and may include the home or community settings.

"Nursing services" means services that include (i) conducting assessments of health status for the purpose of providing nursing care, including the identification of patterns of human response to actual or potential health problems; (ii) providing nursing care to prevent health problems, restore or improve functioning, and promote optimal health and development; and (iii) administering medications, treatment, and regimens prescribed by a licensed physician.

"Nutrition services" means services that include (i) individual assessments in nutritional history and dietary intake; anthropometric, biochemical, and clinical variables; feeding skills and feeding problems; and food habits and food preferences; (ii) developing and monitoring appropriate plans to address the nutritional needs of children eligible for early intervention supports and services based on the findings of individual assessments; and (iii) making referrals to appropriate community resources to carry out nutritional goals.

"Occupational therapy" means services that are designed to improve the child's functional ability to perform tasks in

home, school, and community settings, and include (i) identifying and assessing the child's functional needs and providing interventions related to adaptive development, adaptive behavior, play, and sensory, motor, and postural development; (ii) adapting the environment and selecting, designing, and fabricating assistive and orthotic devices to facilitate development and promote the acquisition of functional skills; and (iii) preventing or minimizing the impact of initial or future impairment, delay in development, or loss of functional ability.

"Parent" means (i) a biological or adoptive parent or parents of a child; (ii) a foster parent, unless state law, regulations, or contractual obligations with a state or local entity prohibit a foster parent from acting as a parent; (iii) a guardian generally authorized to act as the child's parent or authorized to make early intervention, educational, health, or developmental decisions for the child (but not the state if the child is a ward of the state); (iv) an individual acting in the place of a biological or adoptive parent (including a grandparent, stepparent, or other relative) with whom the child lives or an individual who is legally responsible for the child's welfare; or (v) a surrogate parent, when determined necessary in accordance with and assigned pursuant to this chapter. The term "parent" does not include any local or state agency or its agents if the child is in the custody of said agency.

"Participating agencies" means the Departments of Health, Education, Medical Assistance Services, Behavioral Health and Developmental Services, and Social Services; the Departments for the Deaf and Hard-of-Hearing and Blind and Vision Impaired; and the Bureau of Insurance within the State Corporation Commission.

"Payer of last resort" means a funding source that may be used only after all other available public and private funding sources have been accessed.

"Personally identifiable information" means the name of the child, the child's parent, or other family members; the address of the child or the child's family; a personal identifier, such as the child's or parent's social security number; or a list of personal characteristics or other information that, alone or in combination, could be used to identify the child or the child's parents or other family members.

"Physical therapy" means services that promote the child's sensory or motor function and enhance his musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status, and effective environmental adaptation. These services include (i) screening, evaluation for eligibility determination, and assessment of children to identify movement dysfunction; (ii) obtaining, interpreting, and integrating information appropriate to program planning to prevent, alleviate, or compensate for movement dysfunction and related functional problems; (iii) adapting the environment and selecting, designing, and fabricating assistive and orthotic devices to facilitate development and promote the acquisition of functional skills; and (iv) providing individual or group services or treatment to prevent, alleviate, or compensate for movement dysfunction and related functional problems.

"Primary referral sources" means those agencies, providers, entities, and persons who refer children and their families to the early intervention system and include (i) hospitals, including prenatal and postnatal care facilities; (ii) physicians; (iii) parents; (iv) child care programs and early learning programs; (v) local school divisions; (vi) public health facilities; (vii) other public health or social service agencies; (viii) other clinics and health care providers; (ix) public agencies and staff in the child welfare system, including child protective services and foster care; (x) homeless family shelters; and (xi) domestic violence shelters and agencies.

"Psychological services" means services that include (i) administering psychological and developmental tests and other assessment procedures; (ii) interpreting assessment results; (iii) obtaining, integrating, and interpreting information about child behavior and child and family conditions related to learning, mental health, and development; and (iv) planning and managing a program of psychological services, including psychological counseling for children and parents, family counseling, consultation on child development, parent training, and education programs.

"Service coordinator" means a person who holds a certification as an early intervention case manager and is responsible for assisting and enabling children with disabilities and their families to receive the services and rights, including procedural safeguards, that are authorized to be provided under Virginia's early intervention program.

"Sign language and cued language services" means (i) teaching sign language, cued language, and auditory or oral language; (ii) providing oral transliteration services (such as amplification); and (iii) providing sign and cued language interpretation.

"Single point of entry" means the single entity designated by the local lead agency in each local early intervention system where families and primary referral sources make initial contact with the local early intervention system.

"Social work services" means services that include (i) making home visits to evaluate a child's living conditions and patterns of parent-child interaction; (ii) preparing a social or emotional developmental assessment of the child within the family context; (iii) providing individual and family-group counseling with parents and other family members, including appropriate social skill-building activities with the child and parents; (iv) working with identified problems in the living situation (home, community, and any center where early intervention supports and services are provided) that affect the child's use of early intervention supports and services; and (v) identifying, mobilizing, and coordinating community resources and services to enable the child with a disability and his family to receive maximum benefit from early intervention services.

"Speech-language pathology services" means services that include (i) identifying children with communication or language disorders and delays in development of communication skills and identifying and appraising specific disorders and delays in those skills; (ii) referring children with communication or language disorders and delays in development of communication skills for medical or other professional services necessary for the habilitation or rehabilitation; and (iii) providing services for the habilitation, rehabilitation, or prevention of communication or language disorders and delays in development of communication skills.

"State lead agency" means the agency designated by the Governor to receive funds to administer the state's responsibilities under Part C.

"Surrogate parent" means a person assigned by the local lead agency or its designee to ensure that the rights of a child are protected when no parent can be identified; the lead agency or other public agency, after reasonable efforts, cannot locate a parent; or the child is a ward of the state.

"Transportation and related costs" means the cost of travel and other costs that are necessary to enable a child with a disability and his family to receive early intervention supports and services.

"Virginia Interagency Coordinating Council" or "VICC" means the advisory council, established pursuant to § 2.2-2664 of the Code of Virginia, to promote and coordinate Virginia's system of early intervention services.

"Vision services" means services that include (i) evaluating and assessing visual functioning, including the diagnosis and appraisal of specific visual disorders, delays, and abilities that affect early childhood development; (ii) referring for medical or other professional services necessary for the habilitation or rehabilitation of visual functioning disorders, or both; and (iii) providing communication skills training, orientation and mobility training for all environments, visual training, and additional training necessary to activate visual motor abilities.

"Visit" means a face-to-face encounter with the child with a disability or his parent, another family member, or caregiver, or both, for the purpose of providing early intervention supports and services.

"Ward of the state" means a child who, as determined by Virginia, is a foster child or is in the custody of a public children's residential facility. The term does not include a foster child who has a foster parent who meets the definition of "parent."

Part II

Virginia Early Intervention Services System

12VAC35-225-30. Early intervention services applicability, availability, and coordination.

A. This chapter shall apply to state and local lead agencies, early intervention practitioners, and provider agencies.

B. Appropriate early intervention services based on scientifically based research, to the extent practicable, shall be available to all children with disabilities who are eligible for early intervention services in Virginia and their families, including children and families who reside on an Indian reservation geographically located in Virginia or who are homeless and children who are wards of the state.

C. The Virginia Interagency Coordinating Council (VICC) shall promote and coordinate early intervention services in the Commonwealth and shall advise and assist the department.

1. Nonstate agency members of the VICC shall be appointed by the Governor. State agency representatives shall be appointed by their agency directors or commissioners.

2. The VICC membership shall reasonably represent the population and shall be composed as follows:

a. At least 20% shall be parents, including minority parents, of infants or toddlers with disabilities or children with disabilities aged 12 years or younger, with knowledge of, or experience with, programs for children with disabilities. At least one parent member shall be a parent of a child with a disability aged six years or younger;

b. At least 20% shall be public or private providers of early intervention services;

c. At least one member shall be from the Virginia General Assembly;

d. At least one member shall be involved in personnel preparation;

e. At least one member shall be from each of the participating agencies involved in the provision of or payment for early intervention services to children with disabilities and their families. These members shall have sufficient authority to engage in policy planning and implementation on behalf of the participating agency and shall include:

(1) At least one member from the Department of Education, the state educational agency responsible for preschool services to children with disabilities. This member shall have sufficient authority to engage in policy planning and implementation on behalf of the Department of Education;

(2) At least one member from the Department of Medical Assistance Services, the agency responsible for the state Medicaid program;

(3) At least one member from the Department of Social Services, the agency responsible for child care and foster care;

(4) At least one member from the State Corporation Commission, Bureau of Insurance, the agency responsible for regulating private health insurance;

(5) At least one member designated by the Office of the Coordination of Education of Homeless Children and Youth;

(6) At least one member from the Department of Behavioral Health and Developmental Services, the agency responsible for children's mental health;

(7) At least one member from the Department for the Blind and Vision Impaired;

(8) At least one member from the Department for the Deaf and Hard of Hearing; and

(9) At least one member from the Department of Health;

f. At least one member shall be from CHIP of Virginia;

g. At least one member shall be from a Head Start or Early Head Start agency or program in Virginia; and

h. Other members selected by the Governor.

3. The VICC shall operate as follows:

a. The VICC shall have bylaws that outline nomination processes and roles of officers, committees, and other operational procedures;

b. No member of the VICC shall cast a vote on any matter that would provide direct financial benefit to that member or otherwise give the appearance of a conflict of interest under Virginia law;

c. The VICC shall meet, at a minimum, on a quarterly basis;

d. VICC meetings shall be announced in advance in the Commonwealth Calendar and through an announcement to local lead agencies; and

e. VICC meetings shall be open and accessible to the public, and each meeting shall include a public comment period. Interpreters for persons who are deaf and other necessary services for both VICC members and participants shall be provided as necessary and upon request.

4. Subject to approval by the Governor, the VICC shall work with the department to develop an annual budget for VICC expenses that may include the use of Part C funds for the following:

a. Conducting hearings and forums;

b. Reimbursing members of the VICC for reasonable and necessary expenses for attending VICC meetings and performing VICC duties (including child care for parent representatives);

c. Compensating a member of the VICC if the member is not employed or must forfeit wages from other employment when performing official VICC business;

d. Hiring staff; and

e. Obtaining the services of professional, technical, and clerical personnel as may be necessary to carry out its functions under Part C.

5. Except as provided in subdivision 4 e of this subsection, VICC members shall serve without compensation from funds available under Part C.

Part III

Referrals for Early Intervention Services and Supports

12VAC35-225-40. Public awareness and child identification and referral.

A. The department shall develop and implement a public awareness program that focuses on the early identification of infants and toddlers with disabilities and provides information to parents of infants and toddlers through primary referral sources.

B. Local lead agencies and early intervention service providers shall collaborate with the department to prepare and disseminate information to all primary referral sources, including a description of the early intervention services available, a description of the child find system and how to refer a child under the age of three years for eligibility determination or early intervention services, and a central directory.

C. The department, local lead agencies, and early intervention service providers shall collaborate with and assist primary referral sources in disseminating the information in subsection B of this section to parents of infants and toddlers, especially parents with premature infants or infants with other physical risk factors associated with learning or developmental complications.

D. Local lead agencies shall develop and implement local public awareness and child find procedures that include the methods to be used for planning and distributing public awareness materials and the roles of agencies and persons in the community involved in public awareness and child find activities.

E. The department shall maintain a central directory that shall be accessible to the general public through a toll-free number and the Internet. The central directory shall include accurate and up-to-date information about:

1. Public and private early intervention services, resources, and experts available in Virginia;

2. Professional and other groups (including parent support and training and information centers) that provide assistance to children with disabilities and their families; and

3. Research and demonstration projects being conducted in Virginia relating to children with disabilities.

F. The department shall implement a comprehensive child find system that is consistent with Part B of the Individuals with Disabilities Education Act, 20 USC § 1411 et seq. (Part B) and ensures that all children with disabilities who are eligible for early intervention services in Virginia are identified, located, and evaluated for eligibility determination, including:

1. Indian children with disabilities residing on a reservation geographically located in Virginia (including coordination, as necessary, with tribes, tribal organizations, and consortia);

2. Children with disabilities who are homeless, in foster care, and wards of the state;

3. Children who are the subject of a substantiated case of child abuse or neglect; and

4. Children who are identified as directly affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure.

G. The department shall ensure that the child find system is coordinated with all other major efforts to locate and identify children by other state agencies responsible for administering the various education, health, and social service programs relevant to children with disabilities and their families, including Indian tribes, and with the efforts of the:

1. Preschool special education program through the Department of Education;

2. Maternal and Child Health program, including the Maternal, Infant, and Early Childhood Home Visiting Program under Title V of the Social Security Act, as amended;

3. Early Periodic Screening, Diagnosis and Treatment (EPSDT) under Title XIX of the Social Security Act;

4. Programs under the Developmental Disabilities Assistance and Bill of Rights Act of 2000;

5. Head Start and Early Head Start;

6. Supplemental Security Income program under Title XVI of the Social Security Act;

7. Child protection and child welfare programs, including programs administered by, and services provided through, the Department of Social Services, as the foster care agency and as the state agency responsible for administering the Child Abuse Prevention and Treatment Act (CAPTA);

8. Child care programs in Virginia;

9. Programs that provide services under the Family Violence Prevention and Services Act;

10. Virginia's Early Hearing Detection and Intervention (EHDI) system;

11. Children's Health Insurance Program (CHIP) authorized under Title XXI of the Social Security Act;

12. Virginia Newborn Screening Program;

13. Virginia Congenital Anomalies Reporting Education System (VACARES); and

14. Care Connection of Virginia.

H. The department and local lead agencies shall use interagency agreements, memoranda of understanding, or other mechanisms, as needed, to minimize duplication of child find efforts among the programs listed in subsection G of this section and that there will be effective use of the resources available through each public agency and early intervention service providers in Virginia to implement the child find system.

12VAC35-225-50. Referrals to the single point of entry.

A. All local lead agencies shall identify a single point of entry in their respective local early intervention systems to receive all referrals and inquiries from families and primary referral sources. This single point of entry shall be published in local public awareness and child find materials and communicated to potential referral sources.

B. Primary referral sources shall refer to the single point of entry any infant or toddler potentially eligible for early intervention services as soon as possible, but in no case more than seven days, after the child has been identified as potentially eligible.

C. The department shall require that local community services boards responsible for implementing and managing discharge plans required by § 32.1-127 B 6 of the Code of Virginia for substance-abusing postpartum women and their infants refer to the single point of entry any child under the age of three years who is identified as affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure.

D. The Department of Social Services shall refer to the single point of entry any child under the age of three years who is:

1. Identified as affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or

2. The subject of a founded disposition of child abuse or neglect.

E. Early intervention service providers shall refer to the single point of entry any infant or toddler potentially eligible for early intervention services who becomes known to the provider through any source other than the early intervention system.

F. Parental consent shall not be required in order to make a referral to the local early intervention system and the local system shall accept a referral even if the referral source has not informed the family of the referral.

G. Referrals to the local single point of entry may be made by phone, fax, mail, email, web-based system, in writing, or in person.

H. When making a referral, the referral source shall provide, at minimum, the child's or a family member's name and one method of contacting the family.

I. The date on which the local single point of entry receives a referral shall be counted as the first day of the 45-day timeline specified in 12VAC35-225-80 C within which eligibility determination, assessment for service planning, and the initial IFSP meeting shall be completed.

J. The single point of entry shall inform referred families whose children are close to the age of eligibility for early childhood special education services through the local school division under Part B that they have the option to be referred to the local school division instead of or simultaneously with referral to early intervention under Part C.

K. Upon referral, the single point of entry shall begin an early intervention record for the child and assign a service coordinator who will assist the family with intake, eligibility determination, assessment for service planning, and, if eligible, development of an IFSP.

Part IV
Intake, Eligibility, and Assessment

12VAC35-225-60. Intake.

A. For purposes of the early intervention system, including determination of required parental consents or exercise of parental rights, a biological or adoptive parent, when more than one party is qualified under the definition of parent, the biological or adoptive parent must be presumed to be the parent unless that person does not have legal authority to make educational or early intervention decisions for the child. However, if a judicial decree or order identifies a specific person or persons to act as the parent of a child or to make educational or early intervention decisions on behalf of a child, then that person or persons shall be determined to be the parent.

B. The service coordinator shall conduct intake with the family in order to:

1. Inform the family about early intervention services and the IFSP process;

2. Provide the parent with a written notice and explanation of the family's rights and procedural safeguards under Part C, including:

a. A description of what personally identifiable information is maintained, the types of information sought, the methods used in gathering information (including the sources from whom information is gathered), and the uses to be made of the information;

b. The policies that early intervention service providers must follow regarding storage, disclosure to third parties, retention and destruction of personally identifiable information;

c. The rights of parents and children regarding the foregoing information, including their rights under the confidentiality provisions of Part C; and

d. A description of the languages in which this notice of rights and safeguards is available in Virginia;

3. With prior written notice and parent consent, gather information about the child's development and health history to assist in eligibility determination;

4. Facilitate identification of team members for and coordinate scheduling of eligibility determination;

5. Provide the schedule of sliding fees for early intervention services provided under Part C and other payment information; and

6. For children with Medicaid, ensure completion of the paperwork, including development of an Initial Early Intervention Service Coordination Plan and data entry necessary to enroll the child in the Medicaid early intervention benefit. This plan shall end when the child is found ineligible for early intervention; the IFSP is signed; or 90 calendar days from the date of intake, whichever comes first.

12VAC35-225-70. Eligibility criteria.

A. The department shall identify physical and mental conditions with high probability of resulting in developmental delay.

B. A child shall be eligible for early intervention services under Part C if the child is under three years old and has:

1. A developmental delay as measured through the evaluation and assessment procedures described in this section; or

2. A diagnosed physical or mental condition with high probability of resulting in developmental delay.

12VAC35-225-80. Evaluation for eligibility criteria.

A. A child's medical and other records shall be used to establish initial eligibility (without conducting an evaluation for eligibility determination) if those records indicate that the child's level of functioning in one or more developmental areas constitutes a developmental delay or that the child otherwise meets the criteria for an infant or toddler with a disability.

1. If the records document a diagnosed physical or mental condition with a high probability of resulting in developmental delay, then a certified early intervention case manager or certified early intervention professional shall complete and sign the eligibility determination form to document review of the record.

2. If the records document a developmental delay, a certified early intervention professional shall review the record to determine whether it establishes eligibility, completing and signing the eligibility determination form if it does.

B. With prior written notice and parental consent, each child under the age of three years who is referred to the early intervention system shall receive a timely, comprehensive multidisciplinary evaluation to determine eligibility unless eligibility is established under subsection A of this section.

C. Except as provided in subsection A of this section, the local lead agency shall ensure that, with parental consent, the evaluation for eligibility determination and, if the child is eligible, an assessment (of the child and family) and an initial IFSP meeting are completed within 45 days from the date of referral.

D. The 45-day timeline described in subsection C of this section shall not apply for any period when:

1. The child or parent is unavailable to complete the evaluation for eligibility determination, the assessments of the child and family, or the initial IFSP meeting due to exceptional family circumstances that are documented in the child's early intervention record; or

2. The parent has not provided consent for the evaluation for eligibility determination or the assessment of the child despite documented, repeated attempts by the service coordinator or other service provider, or both, to obtain parental consent.

E. In the event that circumstances described in subsection D of this section delay the 45-day timeline, the service coordinator shall ensure:

1. The exceptional family circumstances, repeated attempts to obtain parental consent, or other circumstances resulting in a delay are documented in the child's early intervention record;

2. The evaluation for eligibility determination, the assessments of the child and family, and the initial IFSP meeting are completed as soon as possible after the documented exceptional family circumstances no longer exist, parental consent is obtained, or other circumstances causing a delay no longer exist; and

3. Development of an interim IFSP, if appropriate for the child and family.

12VAC35-225-90. Eligibility determination process.

A. Eligibility determination shall be conducted by a multidisciplinary team of certified early intervention professionals, which may include one individual who is certified as an early intervention practitioner in more than one discipline or profession, and shall include the use of informed clinical opinion.

B. Eligibility determination shall be conducted in a nondiscriminatory manner and with procedures selected that are not racially or culturally discriminatory.

C. Eligibility determination shall be conducted in the native language of the parent or other mode of communication used by the parent unless the early intervention service providers conducting the evaluation of the child determine that the language normally used by the child is developmentally appropriate for the child.

D. No single procedure shall be used as the sole criterion for determining a child's eligibility.

E. Eligibility determination shall include:

1. Use of an evaluation instrument;

2. Taking the child's history (including interviewing the parent);

3. Identifying the child's level of functioning in cognitive, physical, communication, social or emotional, and adaptive development;

4. Gathering information from other sources such as family members, other caregivers, medical providers, social workers, and educators, if necessary, to understand the full scope of the child's unique strengths and needs; and

5. Reviewing medical, educational, or other records.

F. Informed clinical opinion may be used as an independent basis to establish a child's eligibility even when other instruments do not establish eligibility; however, in no event may informed clinical opinion be used to negate the results of instruments used to establish eligibility.

G. The eligibility determination date, methods, participants, and results shall be documented on the eligibility determination form.

H. The service coordinator shall provide the family with a copy and explanation of the eligibility determination form as soon as possible following eligibility determination at no cost to the family.

12VAC35-225-100. Ineligibility for early intervention services.

If, through the process of eligibility determination, a child is found to be not eligible for early intervention services, the service coordinator shall provide the parent with:

1. A prior written notice that the child has been determined to be not eligible, and

2. A copy and explanation of the notice of child and family rights and safeguards including the parent's right to dispute the eligibility determination by any combination of requesting mediation, making a due process complaint, or filing an administrative complaint.

12VAC35-225-110. Assessment for service planning.

A. With prior written notice and parental consent, each child found eligible for early intervention services shall receive:

1. A multidisciplinary assessment of the child's unique strengths and needs and the identification of services appropriate to meet those needs; and

2. A family-directed assessment of the resources, priorities, and concerns of the family and identification of the supports and services necessary to enhance the family's capacity to meet the developmental needs of that infant or toddler.

B. Assessments for service planning shall be conducted by a multidisciplinary team of certified early intervention professionals, which may include one individual who is certified as an early intervention practitioner in more than one discipline or profession, and shall include the use of informed clinical opinion.

C. Assessments shall be conducted in a nondiscriminatory manner and with procedures selected that are not racially, culturally, or linguistically discriminatory.

D. Assessments shall be conducted in the native language of the parent or other mode of communication used by the parent unless the early intervention service providers

conducting the assessment of the child determine that the language normally used by the child is developmentally appropriate for the child.

E. The multidisciplinary assessment of the child shall include:

1. A review of the results of the eligibility determination;

2. Use of a comprehensive assessment tool;

3. Personal observations of the child;

4. Identification of the child's needs in cognitive, physical, communication, social or emotional, and adaptive development; and

5. If the child is new to Virginia's early intervention system, determination of entry ratings on the child outcome indicators required by the U.S. Department of Education, Office of Special Education Programs.

F. The initial family assessment shall be conducted within 45 days from the date of referral if the parent concurs, even if other family members are not available. The family-directed assessment shall:

1. Be voluntary on the part of each family member participating in the assessment;

2. Be based on information obtained through an assessment tool and through an interview with those family members who elect to participate in the assessment;

3. Include the family's description of its resources, priorities, and concerns related to enhancing their child's development; and

4. Be conducted in the native language or other mode of communication used by the family member participating in the assessment, unless clearly not feasible to do so.

G. Early intervention service providers conducting assessments shall document the assessment results in the integrated, comprehensive assessment summary on the IFSP or in a separate written report that is then integrated into the comprehensive assessment summary on the IFSP.

Part V

Service Planning, Delivery, Transition, and Discharge

12VAC35-225-120. Individualized family service plan (IFSP) development.

A. A written IFSP shall be developed and implemented, with parent consent, for each eligible child.

B. The IFSP shall include:

1. The child's name, date of birth, gender, and city or county of residence; IFSP date and the dates the six-month IFSP review is due and dates reviews are completed; child's and family's primary language or mode of communication; parents' and, if requested by the family, other family members' contact information; and the service coordinator's name and contact information;

2. Information about the child's and family's daily routines and activities;

3. The child's present levels of physical (including vision, hearing, motor, and health status), cognitive, communication, social or emotional, and adaptive development based on the information from eligibility determination and assessment for service planning;

4. With the concurrence of the family, a statement of the family's resources, priorities, and concerns related to enhancing the development of the child;

5. The measurable outcomes to be achieved for the child (including preliteracy and language skills, as developmentally appropriate for the child) and the criteria, procedures, and timelines for determining the degree to which progress toward meeting the outcomes is being made and whether revisions to the outcomes or early intervention services identified in the IFSP are necessary;

6. The specific early intervention services, based on peer-reviewed research (to the extent practicable), that are needed to meet the unique needs of the child and family and to achieve the identified outcomes including:

a. Assistive technology devices and services;

b. Audiology services;

c. Developmental services;

d. Counseling services;

e. Family training services;

f. Health services;

g. Medical services;

h. Nursing services;

i. Nutrition services;

j. Occupational therapy;

k. Physical therapy;

l. Psychological services;

m. Service coordination services;

n. Sign language and cued language;

o. Social work services;

p. Speech-language pathology services;

q. Transportation and related costs;

r. Vision services; or

s. Other services, as may be identified by the department;

7. The length, duration, frequency, intensity, method, and location for delivering each service;

8. A statement of the natural environment in which each early intervention service will be provided or a justification made by the IFSP team, including the parent, as to why, based on the child's outcomes, the service cannot be provided in the natural environment;

9. Payment arrangements, if any;

10. To the extent appropriate, the medical and other services that the child or family needs or is receiving through other sources, but that are neither required nor

funded under Part C and the steps the service coordinator or family may take to assist the child and family in securing those other services if those services are not currently being provided;

11. The projected date for the initiation of each early intervention service identified in the IFSP, which shall be as soon as possible but no more than 30 days from the date the parent signs the IFSP unless the IFSP team agrees on a later start date in order to meet the needs of the child or family;

12. The name of the service coordinator who will be responsible for implementing the early intervention services identified in the IFSP; and

13. The steps and services to be taken to support the smooth transition of the child from early intervention services to preschool services under Part B or other appropriate services, if any. The transition steps in the IFSP shall include, but are not limited to, the following:

a. Discussions with, and training of, parents, as appropriate, regarding future placements and other matters related to the child's transition;

b. Procedures to prepare the child for changes in service delivery, including steps to help the child adjust to, and function in, a new setting;

c. Confirmation that the required notification, unless the parent disagrees, and with parental consent additional information (such as copies of evaluations and assessments and the most recent IFSP) needed by the local school division to ensure continuity of services have been sent to the local school division; and

d. Identification of transition services and other activities that the IFSP team determines are necessary to support the transition of the child.

C. A meeting to develop the initial IFSP shall be held within 45 days from the date the referral is received.

D. Meetings of the multidisciplinary IFSP team, which must include two or more certified early intervention practitioners from separate disciplines or professions, shall include the following participants:

1. The parent or parents of the child;

2. Other family members, as requested by the parent, if feasible to do so;

3. An advocate or person outside of the family, if the parent requests that the person participate;

4. The service coordinator who will be responsible for implementing the IFSP;

5. A person or persons directly involved in conducting eligibility determination, assessment for service planning, or both; and

6. As appropriate, persons who will be providing early intervention services to the child or family.

E. Each meeting to develop an IFSP shall:

1. Take place in a setting and at a time that is convenient to the family; and

2. Be conducted in the native language of the family or other mode of communication used by the family, unless it is clearly not feasible to do so.

F. If an IFSP team member is unable to attend an IFSP meeting, the service coordinator shall make arrangements for the person's involvement through other means, which may include participating by telephone, having a knowledgeable authorized representative attend the meeting, or submitting a written report.

G. The service coordinator shall provide prior written notice of the date, time, and location of the IFSP meeting to the family and other participants early enough before the IFSP meeting date to ensure that they will be able to attend.

H. The service coordinator shall assist the parent in preparing for the IFSP meeting and shall ensure that the parent has the information needed in order to fully participate in the meeting.

I. With parental consent, an interim IFSP shall be developed and implemented when an eligible child or the child's family has an immediate need for early intervention services prior to completion of eligibility determination and assessment for service planning.

1. The interim IFSP shall include the name of the service coordinator who will be responsible for implementing the interim IFSP and coordinating with other agencies and persons; the early intervention services that have been determined to be needed immediately, including the frequency, intensity, length, location, and methods of delivery; and the parent's signature indicating consent to implement the interim IFSP.

2. The development of an interim IFSP shall not negate the requirement to complete the eligibility determination and assessment for service planning and develop an initial IFSP within 45 calendar days of referral.

J. The service coordinator shall document in a contact note any circumstances that result in eligibility determination, assessment for service planning, or initial IFSP development occurring more than 45 calendar days after referral.

12VAC35-225-130. IFSP approval and selection of service providers.

A. The service coordinator shall explain the contents of the IFSP to the parent and informed written consent shall be obtained as indicated by the parent's signature and date of signature on the IFSP prior to the provision of early intervention services.

B. The service coordinator shall assist the family in selecting a service provider for each early intervention service listed on the IFSP from among those provider agencies (including independent providers) who are qualified to provide the

services identified on the IFSP, who are in the parent's payer network, and who practice in the area where the child and family live. The parent's choice of service providers shall be documented on the IFSP addendum page, which shall be signed and dated by the parent prior to service delivery.

1. If no early intervention service provider who can support and assist the family in accomplishing the IFSP outcomes is available within the family's Medicaid or private insurance network, then the parent shall be able to choose an early intervention service provider from outside the parent's third party payer network.

2. If there is only one provider agency for the service needed by the child and family, then the parent shall be offered a choice of early intervention service providers from within that one provider agency for services other than service coordination. If the parent elects not to receive services from the one provider agency, then the local lead agency shall work to identify an alternative early intervention service provider.

3. The parent shall be offered the opportunity to select a provider agency any time a new service is added or when a change in provider agency is needed.

4. If the selected provider agency is unable to provide the service due to full provider caseloads or the requested early intervention service provider within that provider agency is unavailable, then the service coordinator shall explain to the parent the option to begin services right away with an available provider or to wait for his chosen provider to become available. If the parent chooses to wait, the service coordinator shall document the parent's decision in a contact note and the delay in start of services shall be considered a family scheduling preference.

5. The service coordinator shall inform the parent that he may request to change his service provider at any time by contacting the service coordinator.

C. The service coordinator shall retain a signed copy of the IFSP and, as soon as possible following development of the IFSP, shall provide a copy to the parent at no cost to the family and to all service providers who participated in assessment or development of the IFSP or will be implementing the IFSP.

12VAC35-225-140. IFSP periodic review and updates.

A. A periodic IFSP review shall be conducted every six months or any time the parent, service coordinator, or another member of the IFSP team identifies the potential need for revisions to the IFSP outcomes or services.

B. Each periodic IFSP review shall provide for the participation of the IFSP team members listed in 12VAC35-225-120 D 1 through D 4. If conditions warrant, provisions must be made for the participation of other representatives identified in 12VAC35-225-120 D.

C. Each periodic IFSP review shall include a determination of the degree to which progress has been made toward achieving the outcomes identified in the IFSP and the need for revisions of the outcomes or early intervention services identified in the IFSP.

12VAC35-225-150. Annual IFSP review.

A. An annual IFSP review shall be conducted to evaluate and revise, as appropriate, the IFSP for each child and the child's family.

B. The annual IFSP review shall include a determination of the child's continuing eligibility to receive early intervention services.

1. If the child's records document a diagnosed physical or mental condition with a high probability of resulting in developmental delay, then a service coordinator or certified early intervention professional shall complete and sign the eligibility determination form to document review of the record.

2. If the child's records document a developmental delay based on ongoing assessment, then a certified early intervention professional shall review the record to determine whether it establishes eligibility and shall complete and sign the eligibility determination form if it does.

3. In all other circumstances, a multidisciplinary team shall review existing health and developmental information gathered through records, parent input, observation, and an evaluation tool, if needed, to determine the child's continuing eligibility. The child's continuing eligibility determination date, methods, participants, and results shall be documented on the eligibility determination form.

4. The service coordinator shall provide the family, at no cost, with a copy and explanation of the eligibility determination form as soon as possible following the eligibility determination.

C. Each annual IFSP review shall be conducted by the child's multidisciplinary team that includes the team members listed in 12VAC35-225-120 D.

D. During the annual IFSP review, the results of any current evaluations and assessments of the child and family shall be used in determining the early intervention services that are needed and will be provided.

12VAC35-225-160. Physician certification.

A. Physician certification shall be required regarding the medical necessity for services if the child (i) is covered by public health insurance (Medicaid, FAMIS, or TRICARE) or by private health insurance that requires such certification and (ii) will receive services that can be reimbursed under that insurance plan. Certification shall be obtained at the initial and annual IFSP and any time a service is added or the frequency of a service is changed through a periodic IFSP review.

B. The service coordinator shall obtain a written certification of medical necessity from a physician (or

physician assistant or nurse practitioner). A written certification requires:

1. A signature on the IFSP;

2. A signed letter referencing the IFSP; or

3. A completed and signed IFSP summary letter.

C. The service coordinator shall ensure that the certification required by this section certifies the IFSP as a whole. Early intervention service providers shall not be permitted to seek physician certification for individual services.

12VAC35-225-170. Service delivery.

A. Each early intervention service listed on a child's IFSP shall begin as soon as possible but no more than 30 days from the date the parent signs the IFSP unless the IFSP team decides on and documents the reasons for a later start date to meet the individual needs of the child and family. The 30-day timeline does not apply to delivery of an assistive technology device, which must be secured as soon as possible after the parent signs the IFSP.

B. Early intervention supports and services shall be provided only by certified early intervention service practitioners.

C. The service coordinator shall be responsible for the following:

1. Assisting parents of children with disabilities in obtaining access to needed early intervention services and other services identified in the IFSP, including making referrals to providers for needed services and scheduling appointments for children and their families;

2. Coordinating the provision of early intervention services and other services (such as educational, social, and medical services that are not provided for diagnostic or evaluative purposes) that the child needs or are being provided;

3. Conducting referral and other activities to assist families in identifying available early intervention service providers;

4. Coordinating, facilitating, and monitoring delivery of early intervention services required to ensure the services are provided in a timely manner;

5. Conducting follow-up activities to determine that appropriate early intervention services are being provided;

6. If the child has Medicaid or FAMIS, the service coordinator shall:

a. Document in a contact note the family's preferred method of contact (face-to-face, phone, email, or text) for the family contacts that are required every three months and any change in the family's preferred method of contact;

b. Make at least one direct contact with the family every three calendar months, beginning no later than the month after the initial IFSP is signed, with the method of contact determined by the family; and

c. Request completion of a health status report by the child's physician every six months.

D. Early intervention service providers shall deliver services in accordance with the IFSP and make a good faith effort to assist each eligible child in achieving the outcomes in the child's IFSP.

E. Early intervention sessions canceled by the provider or missed due to a holiday shall be made up as quickly as possible unless the parent declines a make-up session.

F. Parents may request to change their early intervention service provider at any time by notifying their service coordinator.

12VAC35-225-180. Service documentation.

A. Early intervention service providers shall document all contacts made and all activities completed with or on behalf of families in a contact note within five business days of the contact. All contact notes shall include:

1. The child's first and last names;

2. Type of early intervention service provided;

3. Method of contact;

4. Date of the note and date of the contact, if the note is not written on the same date; and

5. The early intervention provider's signature, with a minimum of first initial and last name, discipline and credentials of the provider, and the date the note is signed by the provider.

B. Contact notes that document a service session also shall include:

1. A narrative description of what occurred during the session including what was done, what the family or other caregiver did during the session (including how they actively participated during the session), how the child responded during the session (including what the child was able to do in relation to outcomes and goals), and suggestions for follow-up;

2. Who was present;

3. Length of session (in minutes);

4. Location or setting in which service was provided;

5. Information from the family about what has happened since the last session; and

6. Plan for the next contact.

C. Contact notes that document a service coordination contact or activity also shall include the length of the contact or activity (in minutes), the service coordination short-term goal that the contact activity is addressing, and progress toward achieving the service coordination goal.

12VAC35-225-190. Transition.

A. A child shall be considered potentially eligible for preschool services under Part B unless there is a clear expectation that the child will no longer require services by

the time he reaches age three years. The determination of whether a particular child receiving early intervention services is potentially eligible for Part B shall be made by that child's IFSP team as part of the transition process.

B. The department shall ensure the parent of a child with disabilities is informed of the availability of services under § 619 of the Individuals with Disabilities Education Act not fewer than 90 days prior to the toddler's third birthday.

C. For each child who is potentially eligible for preschool services under Part B, and unless the parent objects, the service coordinator shall ensure notification to the local school division and the Virginia Department of Education not fewer than 90 days before the child's third birthday or the anticipated date of transition if the child is age two years by September 30 of a given school year.

1. The notification shall include the child's name, date of birth, and parental contact information (including the parents' names, addresses, and telephone numbers).

2. The parent shall be informed in writing, on the IFSP, of the information that will be included in the notification, the earliest date on which the notification will be sent to the local school division and the Virginia Department of Education, and his right to opt out of the notification by initialing the opt out statement on the IFSP.

3. If the parent opts out of the notification, the notification shall not be sent.

D. If a child is potentially eligible for preschool services under Part B, the service coordinator shall, with the approval of the child's family, convene a transition conference among the local early intervention system, the family, and the local school division at least 90 days and (at the discretion of all parties) up to nine months before the child's third birthday, or anticipated date of transition if the child is age two years by September 30 of a given school year, to discuss any services the child may receive under Part B.

E. If a child is not potentially eligible for preschool services under Part B, the service coordinator shall, with the approval of the family, make a reasonable effort to convene a transition conference among the local early intervention system, the family, and providers of other appropriate services, as available, to discuss appropriate services that the child may receive.

F. The service coordinator shall ensure development of a transition plan in the IFSP at least 90 days, and (at the discretion of all parties) up to nine months, before the child's third birthday, or anticipated date of transition if the child is age two years by September 30 of a given school year, for all children exiting early intervention.

1. The family shall be included in the development of the transition plan.

2. The transition plan shall include steps for the child to exit the early intervention system and any transition services that the IFSP team identifies as needed by that child and family.

3. The service coordinator shall review with the parent the program options for a child with a disability for the period from his third birthday through the remainder of the school year.

G. The meeting to develop the transition plan and the transition conference may be combined.

H. The meeting to develop the transition plan and the transition conference, whether combined or held separately, shall meet the requirements of an IFSP meeting in 12VAC35-225-120.

12VAC35-225-200. Referral and discharge.

A. The service coordinator shall transmit, with parental permission, child-specific information (e.g., current IFSP), recent assessment findings, and other pertinent records to the appropriate school division in which the child resides as soon as possible after the notification to the local school division to ensure continuity of services.

B. If the child is found eligible for early intervention services more than 45 but less than 90 days before the child's third birthday, or before April 1 when the child will reach the age of eligibility for special education at the beginning of the upcoming school year, then as soon as possible after eligibility is determined, the service coordinator shall provide the notification required in 12VAC35-225-190 C unless the parent objects to such disclosure.

C. If a child is referred to the local early intervention system less than 45 days before the child's third birthday and that child may be eligible for preschool services under Part B, the service coordinator shall, with parental consent, refer the child to the local school division and Virginia Department of Education, but the local early intervention system shall not be required to conduct an eligibility determination, assessment for service planning, or hold an initial IFSP meeting under these circumstances.

D. The service coordinator shall ensure exit ratings on the child outcome indicators required by the U.S. Department of Education, Office of Special Education Programs are completed prior to discharge from Virginia's early intervention system for all children who had an entry rating and who have been in the early intervention system for six months or longer since their initial IFSP.

1. The exit rating shall be done no more than six months prior to the child's exit from Virginia's early intervention system.

2. Any circumstances that prevent completion of exit ratings shall be documented in a contact note.

E. The service coordinator shall ensure that no early intervention services are provided on or after the child's third birthday.

Part VI
Service Funding and Payment Systems

12VAC35-225-210. Use of Part C funds.

A. Funds available under Part C shall be used for the following activities:

1. To implement and maintain a statewide system of early intervention supports and services for children with disabilities and their families;

2. For direct early intervention supports and services for children with disabilities and their families that are not otherwise funded through other public or private sources; and

3. To expand and improve supports and services for children with disabilities and their families that are otherwise available.

B. Federal Part C funds and state general funds designated for early intervention services under Part C shall be used as the payer of last resort and shall not be used to satisfy a financial commitment for supports and services that would otherwise have been paid for from another public or private source, including any medical program administered by the Department of Defense, but for the enactment of Part C of the Individuals with Disabilities Education Act.

C. The department and local lead agencies shall identify and coordinate all available resources to pay for early intervention services, including federal, state, local, and private sources.

D. The service coordinator shall coordinate the funding sources for early intervention services in each IFSP.

E. If necessary to prevent a delay in the timely provision of appropriate early intervention services to a child or the child's family, funds available under Part C may be used to pay the provider of early intervention supports and services (excluding medical services) and for functions associated with the child find system, eligibility determination, and assessment for service planning pending reimbursement from the agency or entity that has ultimate responsibility for the payment.

F. The department shall establish an interagency agreement with each participating state agency to ensure the provision of, and establish financial responsibility for, early intervention supports and services; to establish procedures for achieving a timely resolution of intra-agency and interagency disputes about payments for a given service or disputes about other matters related to Virginia's early intervention system; and to ensure that no early intervention supports and services to which a child is entitled are delayed or denied because of disputes between agencies regarding financial or other responsibilities.

G. Local lead agencies shall develop interagency agreements, contracts, or memoranda of agreement with as many early intervention service providers as possible to meet the needs of children with disabilities and their families and shall allow families to have access to any certified early intervention service provider in the family's payer network who agrees to comply with all Part C requirements and is working in the local early intervention system area.

12VAC35-225-220. Services provided at public expense.

A. The following services shall be provided at public expense and at no cost to families:

1. Child find activities;

2. Eligibility determination and assessment for service planning;

3. Service coordination;

4. Administrative and coordinative activities related to the development, review, and evaluation of IFSPs and interim IFSPs; and

5. Administrative and coordinative activities related to implementation of procedural safeguards and other components of the statewide early intervention system related to child find, eligibility determination, assessment, and development of IFSPs.

B. Localities shall not be required to provide funding for any costs for early intervention services provided at public expense, either directly or through participating local public agencies.

12VAC35-225-230. System of payments.

A. The department shall establish and implement a system of payments, including a schedule of sliding family fees with monthly caps, for early intervention services provided under Part C. Under that system:

1. Fees shall not be charged to parents for the services a child is otherwise entitled to receive at no cost, including those listed in 12VAC35-225-220;

2. All early intervention services other than those listed in 12VAC35-225-220 shall be subject to family fees;

3. The inability of the parent of a child with a disability to pay for services shall not result in a delay or denial of services to the child or his family, such that if the family meets the criteria for inability to pay, the child shall receive all early intervention services at no cost to the family;

4. Parents shall not be charged any more than the actual cost of services, factoring in any amount received from other payment sources for that service;

5. Charges for early intervention supports and services shall be consistent regardless of the anticipated payment source, and parents with public insurance or benefits or private insurance shall not be charged disproportionately more than parents who do not have public insurance or benefits or private insurance;

6. All parents shall have the opportunity to submit information to establish ability to pay and a monthly cap for family fees. Parents who choose not to provide the required income information shall be charged for all

applicable copayments, deductibles, and the full early intervention rate for services not covered by insurance;

7. The service coordinator shall ensure a family's ability to pay is established and consent for use of private insurance, public benefits, or public insurance is determined at intake for children who are covered by Medicaid or FAMIS and for all other children prior to delivering early intervention services other than those services that must be provided at no cost to the family; and

8. A family's ability to pay shall be reviewed at each annual IFSP and any time the family's financial circumstances change. If the family is unable to provide the required information, it shall be charged for all applicable copayments and deductibles or the full early intervention rate for services not covered by insurance.

B. Family fees collected shall be retained by the local lead agency to support the local early intervention system.

C. Parents who wish to contest the imposition of a fee or the determination of the parents' ability to pay may contest such determinations in accordance with 12VAC35-225-380 A.

12VAC35-225-240. Use of public benefits or public insurance.

A. Parents shall not be required to enroll in public benefits or public insurance programs as a condition of receiving early intervention services, and parental consent shall be required prior to using the public benefits and public insurance of a child or parent if that child or parent is not already enrolled in such a program.

B. Parental consent shall be obtained before the local lead agency or the early intervention service provider discloses, for billing purposes, a child's personally identifiable information to the Department of Medical Assistance Services.

C. In Virginia, use of a child's or parent's public benefits or public insurance to pay for early intervention services shall not:

1. Decrease available lifetime coverage or any other insured benefit for that child or parent under that program;

2. Result in the child's parents paying for services that would otherwise be covered by the public benefits or public insurance program;

3. Result in any increase in premiums or discontinuation of public benefits or public insurance for that child or his parents; or

4. Risk loss of eligibility for the child or that child's parents for home and community-based waivers based on aggregate health-related expenditures.

D. If the parent gives consent for use of his private insurance to pay for early intervention services for a child who is covered by private insurance and by either public benefits or public insurance, the parent shall be responsible for the costs associated with use of the private insurance, as specified in 12VAC35-225-250 E.

E. If the parent does not provide the consent to use or enroll in public benefits or public insurance or to disclose information to the Department of Medical Assistance Services for billing purposes, the local lead agency must still make available the early intervention services on the IFSP to which the parent has provided consent.

12VAC35-225-250. Use of private insurance.

A. The private insurance of a family may not be used to pay for early intervention services unless the parent has provided prior consent.

B. Parental consent to use of private insurance to pay for early intervention services shall be obtained when the local lead agency or early intervention service provider seeks to use the parent's private insurance or benefits to pay for the initial provision of early intervention services and each time there is an increase (in frequency, length, duration, or intensity) in the provision of services in the child's IFSP.

C. The consent requirements in subsections A and B of this section shall also apply when use of private insurance is required prior to use of public benefits or public insurance.

D. If a parent is determined to be unable to pay and does not provide consent for use of private insurance, the lack of consent shall not be used to delay or deny any early intervention services to the child or family.

E. If the parent provides consent for use of the family's private insurance to pay for early intervention services, Part C or other funds may be used to pay for copayment or deductible amounts that exceed the family's monthly cap, unless the family has money in a flexible spending account that automatically pays the early intervention service provider or the family for these costs.

F. Families shall be responsible for paying their insurance premiums.

12VAC35-225-260. Written notification.

When obtaining parental consent for the provision of early intervention services or for use of public or private insurance or benefits, or both, the service coordinator shall ensure the parents receive written information on Virginia's system of payment policies, which includes the following:

1. Required notification to parents of children covered by Medicaid including:

a. Parental consent requirements in 12 VAC35-225-240 B;

b. The cost protections in 12VAC35-225-240 C;

c. The local lead agency responsibility to offer the early intervention services to which the parent has provided consent even if the parent does not provide consent for use of public benefits or public insurance as specified in 12VAC35-225-240 E;

d. The parent's right to withdraw consent for disclosure, for billing purposes, of a child's personally identifiable information to the Department of Medical Assistance Services at any time; and

e. Categories of costs to parents as specified in 12VAC35-225-240 D.

2. Potential costs to the parent when their private insurance is used, which may include copayments, deductibles, premiums, or other long-term costs such as the loss of benefits because of annual or lifetime health insurance coverage caps under the insurance policy;

3. The payment system and schedule of sliding fees that may be charged to the parents for early intervention services;

4. The basis and amount of payments or fees;

5. Information on the determination of ability to pay and inability to pay, including when and how the determination is made;

6. Assurances regarding fees and service provision as specified in 12VAC35-225-230 A 1 and A 3, 4, and 5;

7. The policy on failure to provide the required income information as specified in 12VAC35-225-230 A 5;

8. Policies regarding use of federal or state Part C funds to pay for costs such as insurance copayments or deductibles; and

9. Parent rights as specified in 12VAC35-225-230 C.

12VAC35-225-270. Billing and collections of family fees, public benefits, and insurance.

A. The local lead agency shall ensure billing for and collection of all family fees for the local early intervention system by:

1. Doing all billing and collection of family fees;

2. Contracting with a single entity to bill for and collect all family fees for the local early intervention system; or

3. Assigning the billing and collection of the family fee to a specific early intervention service provider for each child.

B. Early intervention service providers shall routinely, and no less than one time per month, confirm with families whether their insurance has changed and shall notify the local system manager immediately if a child who has or had Medicaid or FAMIS no longer has Medicaid or FAMIS or does not have the Medicaid early intervention benefit, and notify the service coordinator if the child had TRICARE or private insurance coverage and the child no longer has that coverage or the child has newly acquired Medicaid or FAMIS, TRICARE, or private insurance coverage.

C. The local system manager, or his designee, shall provide oversight to ensure Medicaid or FAMIS information is correctly entered into the department's early intervention management information system, ITOTS, to begin and maintain enrollment in the Medicaid early intervention benefit.

12VAC35-225-280. Provider billing for early intervention services.

A. In order to receive reimbursement from federal or state Part C funds as the payer of last resort, early intervention service providers shall:

1. Have a contractual relationship with the local early intervention system; and

2. Submit a contact log or contact notes to the local lead agency no later than the 21st of each month for all services provided in the previous month, including any service for which reimbursement is sought from Part C funds.

B. Early intervention service providers shall accept Medicaid reimbursement for medically necessary early intervention services as payment in full.

C. In order to bill Medicaid for early intervention services other than service coordination, the provider shall:

1. Be certified as an early intervention practitioner;

2. Enroll with the Department of Medical Assistance Services as an early intervention provider;

3. Provide services to children who are determined eligible for early intervention services under Part C;

4. Provide covered services as listed on the child's IFSP and, with the exception of the assessment for service planning and IFSP meetings, services that are approved by a physician, physician's assistant, or nurse practitioner; and

5. Comply with all other applicable Department of Medical Assistance Services requirements.

D. In order to bill Medicaid for service coordination, the provider shall:

1. Be certified as an early intervention case manager;

2. Enroll with the Department of Medical Assistance Services as an early intervention provider;

3. Deliver service coordination in accordance with a signed initial early intervention service coordination plan or a signed individualized family service plan (IFSP);

4. Provide at least one activity during the month being billed to the child, the family, service providers, or other organizations on behalf of the child or family in order to coordinate supports and services and assist the family in accessing needed resources and services;

5. Document the contact or communication completely and correctly in accordance with 12VAC35-225-180;

6. Make a phone, email, text, or face-to-face contact with the family at least one time every three calendar months, or document attempts of such contacts;

7. Ensure documented face-to-face interaction between the service coordinator and the family at the development of the initial IFSP and the annual IFSP along with documentation that the service coordinator observed the

child during the calendar month that the IFSP meeting was held;

8. Submit the health status indicator questions to the child's physician every six months; and

9. Comply with all other applicable Department of Medical Assistance Services requirements.

E. Children who are dually enrolled in Virginia's early intervention system and in Medicaid or FAMIS shall receive service coordination under the early intervention targeted case management program.

Part VII
Procedural Safeguards

12VAC35-225-290. Notice of rights and procedural protections.

A. The service coordinator shall provide a written copy and explanation of the child's and family's rights and procedural safeguards at the intake visit and shall provide ongoing information and assistance to the family regarding their rights and procedural safeguards throughout the period of the child's eligibility for early intervention services.

B. The notice and explanation provided at the intake visit shall fully inform parents about the confidentiality requirements under Part C.

12VAC35-225-300. Surrogate parent selection.

A. A surrogate parent shall be assigned to a child if no parent of the child can be identified, the local system cannot after reasonable efforts locate a parent, or the child is a ward of the state. The service coordinator shall make reasonable efforts to ensure that a surrogate parent is assigned to the child within 30 days after determining the child needs a surrogate parent. In implementing the surrogate parent requirements, if the child is in foster care or a ward of the state, the service coordinator shall consult with the public agency that has been assigned care of the child.

B. The person selected as a surrogate parent shall:

1. Not be an employee of any public agency or early intervention service provider that provides early intervention services, education, care, or other services to the child or any member of the child's family;

2. Have no personal or professional interest that conflicts with the interest of the child he represents; and

3. Have knowledge and skills that ensure adequate representation of the child.

C. A surrogate parent assigned to a child pursuant to this section shall have the same rights as a parent for all purposes in the early intervention system.

12VAC35-225-310. Prior written notice.

A. Prior written notice shall be given to the parent at least five days before an early intervention provider proposes or refuses to initiate or change identification, eligibility determination, or placement of the child or the provision of early intervention services to the child or family.

B. The prior written notice shall be in sufficient detail to inform the parent of the action being proposed or refused, the reasons for taking the action, and available procedural safeguards, including dispute resolution options.

C. The prior written notice shall be written in language understandable to the general public and shall be provided in the native language of the parent or other mode of communication used by the parent, unless it is clearly not feasible to do so. If the parent does not use a written language, documentation of the procedures used to provide prior notice shall be included in a contact note.

12VAC35-225-320. Parental consents.

A. Written parental consent shall be obtained prior to all eligibility determinations and assessments; providing early intervention services; disclosing personally identifiable information to anyone other than authorized representatives, officials or employees of the department, local lead agency, or early intervention service providers collecting, maintaining, or using information under Part C and using public or private insurance or benefits. When seeking parental consent, the service coordinator shall ensure the following:

1. The parent is fully informed of all information relevant to the activity for which consent is sought, in the parent's native language;

2. The parent understands and agrees in writing to the carrying out of the activity for which consent is sought;

3. The consent form describes that activity and lists the early intervention records (if any) that will be released and to whom they will be released; and

4. The parent understands that the granting of consent is voluntary on the part of the parent and may be revoked at any time and that, if a parent revokes consent, that revocation is not retroactive.

B. The parent shall have the right to accept or decline specific early intervention services identified by the IFSP team and may decline a service after first accepting it without jeopardizing his right to obtain other early intervention services.

C. If a parent does not give consent for eligibility determination, assessment, or provision of early intervention services, the service coordinator shall document reasonable efforts to ensure that the parent is fully aware of the nature of the eligibility determination, assessment, or the services that would be available and understands the child will not be able to receive the eligibility determination, assessment, or services unless consent is given.

D. If a parent refuses to provide consent to disclose personally identifiable information, the service coordinator shall explain to the family the impact of their decision to refuse consent for the release of information, including why consent is needed, how the information will be used, and how

the absence of that information might affect the ability of their child to receive early intervention services. The explanation provided and the parent's final decision regarding consent to disclose the information shall be documented in a contact note.

E. Due process hearing procedures shall not be used to challenge a parent's refusal to provide any consent required under this section.

12VAC35-225-330. Early intervention records.

A. The local lead agency shall maintain a central early intervention record for each child referred to the local early intervention system. The central early intervention record must include the following:

1. Accurate demographic and referral information;

2. Signed releases and consents;

3. Other completed procedural safeguards forms;

4. Completed and signed initial early intervention service coordination plan, if the child has Medicaid or FAMIS;

5. Assessment reports;

6. Medical reports;

7. All other documentation collected during eligibility determination and IFSP development, including reports from previous outside screenings and assessments;

8. Completed eligibility determination form or forms;

9. All IFSPs developed, including documentation of periodic reviews;

10. Contact logs or contact notes submitted by providers, including service coordinators;

11. Copies of all correspondence to and from the local lead agency or its providers with or on behalf of the family;

12. Court orders related to service provision, custody issues, or parental rights;

13. Documentation of the family's ability to pay, unless it is kept in a separate financial file; and

14. Record access log listings of any individual, except parents and authorized employees, obtaining access to the early intervention record, including the individual's name, date of access, and purpose of access.

B. Each early intervention service provider shall maintain a clinical working file that must include, at a minimum:

1. A copy of the IFSP (including annual and periodic reviews),

2. Contact notes, and

3. Any completed screening or assessment protocols if not housed in the early intervention record.

C. Early intervention service providers working in the provider agency where the central early intervention record is housed shall have the option to maintain the items listed above in the central early intervention record instead of in a separate clinical or working file.

12VAC35-225-340. Confidentiality of personally identifiable information.

A. The department, local lead agencies, and all early intervention service providers shall ensure the confidentiality of personally identifiable information collected, maintained, or used under Part C from the point in time when the child is referred to the local early intervention system until the later of when the provider agency is no longer required to maintain or no longer maintains that information under applicable federal and Virginia laws. Confidentiality shall be maintained at the collection, maintenance, use, storage, disclosure, and destruction stages.

B. One official at each local lead agency and each early intervention service provider shall assume responsibility for ensuring confidentiality of any personally identifiable information.

C. The department, local lead agency, and all early intervention service providers shall train all persons collecting or using personally identifiable information regarding federal and Virginia requirements for safeguarding records and personally identifiable information.

D. Each local lead agency and early intervention service provider shall maintain, for public inspection, a current listing of the names and positions of those employees within the local lead agency and early intervention service provider who have access to personally identifiable information.

12VAC35-225-350. Inspection and review of early intervention service records.

A. Parents of infants and toddlers who are referred to or receive early intervention services shall have the right to inspect and review all early intervention records collected, maintained, or used by the local lead agency or early intervention service providers, including records related to eligibility determination, assessments for service planning, development and implementation of IFSPs, provision of early intervention services, individual complaints involving the child, or any other part of the child's early intervention record.

B. The local lead agency and early intervention service providers shall provide parents, upon request, a list of the types and locations of early intervention records collected, maintained, or used by the local lead agency and early intervention service providers.

C. If any early intervention record includes information on more than one child, the parent has the right to inspect and review only the information relating to his child or to be informed of that specific information.

D. The right to inspect and review records includes the right to:

1. A response from the local lead agency or early intervention service provider to reasonable requests for explanations and interpretations of the early intervention records;

2. Request that the local lead agency or early intervention service provider provide copies of the early intervention records if failure to provide those copies would effectively prevent the parent from exercising the right to inspect and review the records; and

3. Have a representative of their choice inspect and review the records.

E. The local lead agency and early intervention service providers shall comply with a parent's request to inspect and review records without unnecessary delay, before any meeting regarding an IFSP or a due process hearing, and in no case more than 10 days after the request is made.

F. Upon request, the parent shall receive one copy of his child's early intervention record at no cost to the parent. After the parent has received one copy of the child's early intervention record at no cost, the local lead agency or early intervention service provider may charge a fee for additional copies. However, the local lead agency or early intervention service provider shall not charge a fee for additional copies of the child's records if the fee effectively prevents the parent from exercising his right to inspect and review those records. The local lead agency or early intervention service provider shall not charge a fee to search for or to retrieve information and shall provide at no cost to parents a copy of each eligibility determination, assessment, and IFSP as soon as possible after each IFSP meeting.

G. The local lead agency and early intervention service provider shall presume the parent has authority to inspect and review records relating to his child unless the local lead agency or early intervention service provider has been provided documentation that the parent does not have that authority under applicable Virginia laws governing such matters as custody, foster care, guardianship, separation, and divorce.

H. The local lead agency and early intervention service providers shall keep a record of parties obtaining access to early intervention records collected, maintained, or used by the early intervention system unless such access is by the parent or parents or authorized representatives and employees of the participating agency. The record of access shall include the name of the party accessing the record, the date access was given, and the purpose for which the party is authorized to use the early intervention record.

12VAC35-225-360. Request to amend information in the early intervention record.

A. A parent who believes that information in the early intervention records collected, maintained, or used in the early intervention system is inaccurate, misleading, or violates the privacy or other rights of the child or parent shall have the right to request that the agency that maintains the information amend the information.

B. When a parent requests that information in a record be amended, the local lead agency or early intervention service provider shall decide whether to amend the information in accordance with the request within a reasonable period of time after the request is received.

C. If the local lead agency or early intervention service provider refuses to amend the information in accordance with the request, the local lead agency or early intervention service provider shall inform the parent of the refusal and advise the parent of the right to a local hearing to challenge the information in his child's early intervention record.

1. A hearing shall be held within 30 days after the request is received by the local lead agency or early intervention service provider from the parent.

2. The parent shall be given written notice of the date, place, and time at least 15 days before the hearing.

3. The hearing may be conducted by any person, including an official of the local lead agency or early intervention service provider, who does not have a direct interest in the outcome of the hearing.

4. The local lead agency or early intervention service provider shall give the parent a full and fair opportunity to present evidence relevant to the issues raised. The parent may, at his own expense, be assisted or represented by persons of his own choice, including an attorney.

5. The local lead agency or early intervention service provider shall issue its decision in writing to the parent within five business days after the conclusion of the hearing.

6. The decision of the local lead agency or early intervention service provider shall be based solely on the evidence presented at the hearing and shall include a summary of the evidence and the reasons for the decision.

7. If the hearing determines that the information is inaccurate, misleading, or in violation of the privacy or other rights of the child or parent, the local lead agency or early intervention service provider shall amend the information accordingly and inform the parent in writing.

8. If the hearing determines that the information is not inaccurate, misleading, or in violation of the privacy or other rights of the child or parent, the local lead agency or early intervention service provider shall inform the parent of the right to place in the early intervention record a statement commenting on the information or setting forth any reasons for disagreeing with the decision of the local lead agency or early intervention service provider. Any such explanation placed in the early intervention record shall be maintained as part of the early intervention record as long as the record or contested portion is maintained by the agency. If the early intervention record or the contested portion of the record is disclosed by the local lead agency or early intervention service provider to any party, the explanation shall also be disclosed to the party.

D. If the parent is not satisfied with the local hearing determination, the local lead agency or early intervention

service provider shall advise the parent of his right to file a due process complaint with the department.

12VAC35-225-370. Maintenance of early intervention service records.

A. The local lead agency and early intervention service providers shall inform the parent when personally identifiable information collected, maintained, or used in the early intervention system is no longer needed to provide services to the child and shall destroy the information at the request of the parent.

B. A child's early intervention record shall be destroyed at the request of his parent. However, a permanent record of a child's name, date of birth, parent contact information (including address and phone number), names of service coordinator or coordinators, early intervention service provider or providers, and exit data (including year and age upon exit and any programs entered into upon exiting) may be maintained without time limitation.

C. The local lead agency and early intervention service providers shall ensure early intervention records are maintained for a minimum of three years following the child's discharge from the local early intervention system.

Part VIII
Dispute Resolution

12VAC35-225-380. Notification of complaint resolution options.

A. The department shall ensure the availability of procedures for resolving complaints through mediation, an administrative complaint, or a due process hearing.

B. The service coordinator shall inform the child's parent of all options for resolving complaints by providing written and verbal information that explains the options and the procedures for each and shall provide the parent with a contact at the department who can assist the parent in filing a complaint.

12VAC35-225-390. Mediation.

A. Mediation shall be voluntary on the part of all parties; shall be available at any time to parties to disputes involving any matter under Part C, including matters arising prior to the filing of a due process complaint; and shall not be used to delay or deny a parent's right to a due process hearing.

B. The department shall maintain a list of individuals who are qualified mediators and knowledgeable in laws and regulations relating to the provision of early intervention services and shall select mediators on a random or rotational basis.

C. An individual who serves as a mediator shall not be an employee of the department, a local lead agency, or an early intervention service provider that is involved in the provision of early intervention services or other services to the child and shall not have a personal or professional interest that conflicts with the person's objectivity. A person who otherwise qualifies as a mediator shall not be considered an employee of the department, a local lead agency, or an early intervention provider solely because he is paid by the agency to serve as a mediator.

D. The department shall appoint a trained and impartial mediator within five days of receiving the request for mediation.

E. Each session in mediation shall be scheduled in a timely manner and shall be held in a location that is convenient to the parties involved in the dispute.

F. Mediation, including a written mediation agreement reflecting agreements reached by the parties to the dispute, shall be completed within 15 calendar days of the receipt by the department of notice that both parties have agreed to mediation. If resolution is not reached within 15 days, the department shall inform the parents in writing that they may request a due process hearing.

G. Extensions of the 15-day timeline may be granted for good cause. If there is a simultaneous request for mediation and a due process hearing, an extension shall not result in a violation of the 30-day timeline for completion of the due process hearing.

H. If the parties resolve the dispute through the mediation process, the parties shall execute a legally binding agreement that sets forth the resolution, states that all discussions that occurred during the mediation process are confidential and may not be used as evidence in any subsequent due process or civil proceeding, and is signed by both the parent and a representative of the local lead agency or early intervention service provider who has the authority to bind that agency.

I. The department shall bear the full cost of the mediation process.

12VAC35-225-400. Due process hearing.

A. Due process hearings shall be available to the parent of any child referred to the local early intervention system to resolve complaints regarding an early intervention provider's proposal or refusal to initiate or change his child's identification, eligibility determination, or placement or to the provision of early intervention services to the child or family.

B. The department shall arrange for the appointment of an impartial hearing officer within five days following receipt of a request for a due process hearing. The due process hearing officer shall:

1. Not be an employee of the department, a local lead agency, or an early intervention service provider involved in the provision of early intervention services or the care of the child. A person who is otherwise qualified shall not be considered an employee of the department, a local lead agency, or an early intervention provider solely because he is paid by the agency to implement the due process hearing procedures;

2. Not have a personal or professional interest that conflicts with his objectivity in implementing the process;

3. Have knowledge about the provisions under Part C and the needs of and early intervention services available for children with disabilities and their families;

4. Listen to the presentation of relevant viewpoints about the due process complaint;

5. Examine information relevant to the issues;

6. Seek to reach a timely resolution of the due process complaint; and

7. Provide a record of the proceedings, including a written decision.

C. The due process hearing shall be carried out at a time and place that is reasonably convenient for the parent.

D. Any parent involved in a due process hearing shall have the right to:

1. Be accompanied and advised by counsel and by individuals with special knowledge or training with respect to early intervention services for children with disabilities;

2. Present evidence and confront, cross-examine, and compel the attendance of witnesses;

3. Prohibit the introduction of any evidence at the hearing that has not been disclosed to the parent at least five days before the hearing;

4. Obtain a written or electronic verbatim transcript of the hearing at no cost to the family; and

5. Receive a written copy of the findings of fact and decisions at no cost to the parent.

E. The due process hearing shall be conducted and a written decision shall be mailed to all parties within 30 days of receipt by the department of the parent's request for a due process hearing. The hearing officer may grant a specific extension of the timeline at the request of either party.

F. Any party aggrieved by the findings and decision issued pursuant to a due process hearing shall have the right to bring a civil action in Virginia or federal court.

G. During the pendency of any proceeding involving a due process complaint, unless the local lead agency and the parent of the child agree otherwise, the child shall continue to receive the appropriate early intervention services in the setting identified in the IFSP for which the parent has provided consent. If the due process complaint involves an application for initial services, the child shall receive those services that are not in dispute.

H. Costs for due process hearings shall be equally shared by the local lead agency and the department. The costs shared include expenses of the hearing officer (i.e., time, travel, secretarial, postal, and telephone expenses), expenses incurred by order of the hearing officer (i.e., independent educational evaluations, deposition, or transcript), and expenses for making a record of a hearing (i.e., hearing tapes).

I. The department shall not be responsible for expenses incurred for witnesses (except where hearing officers subpoena witnesses on their own initiative) or for the parent's attorney fees.

12VAC35-225-410. Administrative complaint.

A. An individual or organization (including those from another state) shall have the right to file an administrative complaint with the department alleging that the local lead agency, an early intervention service provider, or participating agency has violated a requirement of Part C.

B. The department shall widely disseminate to parents and other interested individuals, including parent training and information centers, protection and advocacy agencies, and other appropriate entities the procedures for filing and resolving administrative complaints.

C. An administrative complaint shall be made in writing to the department, allege a violation that occurred not more than one year prior to the date the complaint is received by the department, and include the following:

1. A statement that the department, local lead agency, or early intervention service provider has violated a requirement of Part C;

2. The facts on which the statement is based;

3. The signature and contact information for the complainant; and

4. If alleging violations with respect to a specific child, (i) the name and address of the child; (ii) the name of the early intervention service provider serving the child; (iii) a description of the problem, including facts related to the problem; and (iv) a proposed resolution to the problem to the extent known and available to the complainant if there is one at the time the complaint is filed.

D. The party filing the complaint shall forward a copy of the complaint to the local lead agency or the early intervention service provider serving the child at the same time the party files the complaint with the department.

E. Within 60 days after a complaint is received, the department shall:

1. Carry out an independent onsite investigation, if the department determines that an investigation is necessary;

2. Give the complainant the opportunity to submit additional information, either orally or in writing, about the allegations in the complaint;

3. Provide the local lead agency other participating agency, or early intervention service provider with an opportunity to respond to the complaint within 10 days by providing a proposal to resolve the complaint and an opportunity to voluntarily engage in mediation;

4. Review all relevant information and make an independent determination as to whether the local lead agency, other participating agency, or early intervention service provider is violating a requirement of Part C; and

5. Issue a written decision to the complainant that addresses each allegation in the complaint and contains findings of fact and conclusions and the reasons for the final decision.

The final decision may include recommendations for technical assistance, negotiations, and corrective actions to achieve compliance, as well as timelines for completion.

If, in resolving an administrative complaint, the department finds a failure to provide appropriate early intervention services then the final decision shall address the corrective actions appropriate to address the needs of the child who is the subject of the complaint and his family (such as compensatory services or monetary reimbursement) and appropriate future provision of services for all children with disabilities and their families.

F. The 60-day timeline for resolving an administrative complaint may be extended only if exceptional circumstances exist with respect to a particular complaint or the parent (or individual or organization) and the local lead agency, other participating agency, or early intervention service provider involved in the complaint agree to extend the timeline to engage in mediation.

G. If the administrative complaint received by the department is also the subject of a due process hearing or contains multiple issues of which one or more are part of that due process hearing, the department shall set aside any part of the complaint that is being addressed in the due process hearing until the conclusion of the hearing. Any issue in the complaint that is not part of the due process hearing shall be resolved using the 60-day time limit and the administrative complaint procedures.

H. If an issue is raised in a complaint that has previously been decided in a due process hearing involving the same parties, the hearing decision shall be binding, and the department shall inform the complainant to that effect.

I. A complaint alleging the local lead agency, other participating agency, or early intervention service provider's failure to implement a due process hearing decision shall be resolved by the department.

J. A final decision of the department pursuant to this section shall be a final case decision that may be appealed pursuant to the Virginia Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia).

12VAC35-225-420. Appeal to the Department of Medical Assistance Services.

A. In addition to the dispute resolution options described in this chapter, Medicaid or FAMIS recipients shall have the right to file an appeal with the Department of Medical Assistance Services when they disagree with certain actions. Actions that may be appealed include:

1. Disagreement about the child's eligibility for services;

2. The provision of early intervention services, including those listed on the IFSP; and

3. The frequency and length of services in the IFSP.

B. To ensure this right to appeal, the service coordinator shall provide the family with written information on the appeals process, regardless of whether or not the family expresses agreement or disagreement, if the child is found ineligible; the local system is refusing to initiate a service the family is requesting or is refusing to provide a service at the frequency or length desired by the family; or a service is decreased or ended, unless the family requested the service be decreased or ended.

C. Families shall follow all applicable Department of Medical Assistance Services requirements when filing an appeal.

Part IX

Early Intervention Practitioner Certification Requirements

12VAC35-225-430. Certification required for early intervention professionals and early intervention specialists.

A. Individual practitioners of early intervention services, with the exception of physicians, audiologists, and registered dietitians, shall be certified by the department as early intervention professionals or early intervention specialists.

B. Certified early intervention professionals shall have expertise in a discipline trained to enhance the development of children with a disability, as evidenced by state licensure, including application for state licensure if the discipline authorizes practice in Virginia while the application is pending and the individual practitioner meets all applicable requirements for such practice; state endorsement; or certification by a national professional organization. Qualified personnel in the following disciplines may seek certification from the department as early intervention professionals:

1. Counselors.

a. Licensed professional counselors licensed by the Virginia Board of Counseling; and

b. School counselors (Pre K - 12) endorsed by the Virginia Board of Education;

2. Behavior analysts certified through the Behavior Analyst Certification Board as a Board Certified Behavior Analyst (BCBA);

3. Educators.

a. Educators licensed by the Virginia Board of Education with endorsement in Special Education - Early Childhood (Birth - 5);

b. Educators licensed by the Virginia Board of Education with endorsement in Early/Primary Education (Pre K - 3);

c. Educators licensed by the Virginia Board of Education with endorsement in Career and Technical Education - Family and Consumer Services;

d. Educators licensed by the Virginia Board of Education with endorsement in Special Education - Hearing Impairments (Pre K - 12);

e. Educators licensed by the Virginia Board of Education with endorsement in Special Education - Visual Impairments (Pre K - 12); and

f. Educators with a technical professional license issued by the Virginia Board of Education in Career and Technical Education - Family and Consumer Sciences;

4. Family and consumer science professionals certified through the American Association of Family and Consumer Sciences (AAFCS). Individuals certified by the AAFCS after June 30, 2009, shall meet certification requirements in family and consumer sciences - human development and family studies;

5. Marriage and family therapists licensed by the Virginia Board of Counseling;

6. Music therapists certified by the Certification Board for Music Therapists (CBMT);

7. Nurses.

a. Nurse practitioners licensed by the Virginia Board of Nursing; and

b. Registered nurses licensed by the Virginia Board of Nursing;

8. Occupational therapists licensed by the Virginia Board of Medicine;

9. Orientation and mobility specialists certified by the National Blindness Professional Certification Board as a National Orientation and Mobility Certificant (NOMC) or certified by the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP) as a Certified Orientation and Mobility Specialist (COMS);

10. Physical therapists licensed by the Virginia Board of Physical Therapy;

11. Psychologists.

a. Applied psychologists licensed by the Virginia Board of Psychology;

b. Clinical psychologists licensed by the Virginia Board of Psychology; and

c. School psychologists licensed by the Virginia State Board of Education with an endorsement in school psychology;

12. Social workers.

a. Licensed clinical social workers licensed by the Virginia Board of Social Work; and

b. School social workers licensed by the Virginia State Board of Education with an endorsement as a school social worker;

13. Speech-language pathologists licensed by the Virginia Board of Audiology and Speech-Language Pathology; and

14. Therapeutic recreation specialists certified by the National Council on Therapeutic Recreation.

C. Certified early intervention specialists shall hold a minimum of a high school diploma or general equivalency diploma. Qualified personnel in the following disciplines may seek certification from the department as early intervention specialists:

1. Assistant behavior analysts certified through the Behavior Analyst Certification Board as a Board Certified Assistant Behavior Analyst (BCaBA);

2. Early intervention assistants whose qualifications have been approved by the Department of Behavioral Health and Developmental Services;

3. Licensed social workers licensed by the Virginia Board of Social Work;

4. Nurses.

a. Certified nurse aides certified by the Virginia Board of Nursing; and

b. Licensed practical nurses licensed by the Virginia Board of Nursing;

5. Occupational therapy assistants licensed by the Virginia Board of Medicine; and

6. Physical therapy assistants licensed by the Virginia Board of Physical Therapy.

D. Certified early intervention professionals and certified early intervention specialists shall demonstrate knowledge of early intervention principles and practices, including infant and toddler development, family-centered practice and multidisciplinary team practice, by successful completion of the early intervention principles and practices online training modules administered by the department. A score of at least 80% accuracy on each module's competency test shall be required for successful completion.

12VAC35-225-440. Supervision requirements.

A. Certified early intervention professionals providing supervision to other early intervention personnel shall complete the supervision training administered by the department. A score of at least 80% accuracy on the competency test shall be required for successful completion.

B. Certified early intervention specialists shall work under the supervision of a certified early intervention professional who has completed the required supervision training.

12VAC35-225-450. Certification required for early intervention service coordinators.

A. Individual practitioners who provide service coordination to children enrolled in early intervention services shall be certified by the department as early intervention case managers.

B. Certified early intervention case managers shall hold:

1. A minimum of an undergraduate degree in any of the following fields:

a. Allied health, including rehabilitation counseling, recreation therapy, occupational therapy, physical therapy, or speech or language pathology;

b. Child and family studies;

c. Counseling;

d. Early childhood;

e. Early childhood growth and development;

f. Early childhood special education;

g. Human development;

h. Human services;

i. Nursing;

j. Psychology;

k. Public health;

l. Social work;

m. Special education – hearing impairments;

n. Special education – visual impairments; or

o. Other related field or interdisciplinary studies approved by the department;

2. An associate degree in a related field such as occupational therapy assistant, physical therapy assistant, or nursing; or

3. A high school diploma or general equivalency diploma, or an undergraduate degree in an unrelated field, plus three years' full-time experience, at least 32 hours per week, coordinating direct services to children and families and implementing individual service plans. Direct services address issues related to developmental and physical disabilities, behavioral health or educational needs, or medical conditions. Experience may include supervised internships, practicums, or other field placements.

C. Qualified persons shall demonstrate:

1. Expertise in the provision of service coordination services, as evidenced by successful completion of case management training approved by the department. A score of at least 80% accuracy on the case management training competency test shall be required for successful completion.

2. Knowledge of early intervention principles and practices, including infant and toddler development, family-centered practice and multidisciplinary team practice, by successful completion of the early intervention principles and practices online training modules administered by the department. A score of at least 80% accuracy on each module's competency test shall be required for successful completion.

12VAC35-225-460. Initial certification and recertification processes.

A. To apply for initial certification as an early intervention professional, early intervention specialist, or early intervention case manager, applicants shall:

1. Obtain the designated early intervention certification application package from the department; and

2. Submit a completed and signed application package to the department with:

a. A signed assurance that the applicant will comply with all federal and state early intervention requirements;

b. Documentation of the applicant's educational credentials, professional certification, licensing, endorsement, or other qualification for the practice of his discipline in the Commonwealth of Virginia; and

c. Documentation of the applicant's successful completion of the training required by the department.

B. Any initial certification granted to a person who has made application for state certification, licensure, endorsement, or other qualification in his discipline and is awaiting licensure shall be valid only as long as that person meets the requirements of his discipline to practice in Virginia.

C. Three-year recertification. At least 30 days prior to the expiration of the practitioner's certification period, the certified early intervention practitioner shall submit an application for recertification to the department. This application shall include:

1. Documentation of the practitioner's continuing professional certification, licensing, endorsement, or other qualification for the practice of his discipline in the Commonwealth of Virginia; and

2. Documentation that the practitioner has successfully completed at least 30 hours of continuing learning activities during the three-year certification period. The continuing learning activities shall address one or more of the following: (i) evidenced-based practices in early intervention services; (ii) changes in federal or state law, regulations, or practice requirements; (iii) topics identified on a personal development plan; (iv) training needed for new responsibilities relating to early intervention services; and (v) training required by the department. For each continuing learning activity, documentation shall include a description of the activity and sponsoring organization, if applicable; the date or dates of training; the number of hours; and a copy of a certificate or verification of attendance, if applicable.

12VAC35-225-470. Notice of decision on application for certification or recertification.

The department shall provide written notice of the decision on the application for certification or recertification within 30 days of the receipt of a completed application and required documentation.

12VAC35-225-480. Early intervention practitioner database.

Early intervention practitioners meeting the requirements for certification shall be included in the practitioner database

maintained by the department. Early intervention practitioners are responsible for notifying the department of any change that may affect their early intervention certification status or their participation in Virginia's early intervention services system.

12VAC35-225-490. Restoration of expired certifications.

A. The department shall notify practitioners in writing of the date their early intervention certification expired and that the early intervention practitioner has been placed on inactive status in the practitioner database maintained by the department.

B. Early intervention practitioners whose early intervention certification has expired may apply to the department for restoration of their certification.

C. The department may restore early intervention certification for early intervention practitioners under the following conditions:

1. The individual's early intervention certification has been lapsed for a period of less than one year; and

2. The early intervention certification:

a. Has lapsed because the early intervention practitioner failed to complete the three-year recertification requirements and the practitioner provides documentation to the department demonstrating (i) he is currently qualified for the practice of his discipline in the Commonwealth of Virginia and (ii) he has completed at least 30 hours of training addressing one or more of the topics specified in 12VAC35-225-450 B 2; or

b. Has lapsed because the early intervention practitioner's discipline-specific qualification expired and the practitioner provides documentation to the department demonstrating that he now holds a current license, certification, endorsement, or other qualification for the practice of his discipline in the Commonwealth of Virginia.

D. The department shall provide written notice of its decision to approve or deny the early intervention practitioner's request for restoration of his early intervention certificate within 30 days after the department receives a completed request and all required documentation.

E. Upon restoration of the practitioner's early intervention certification, the department shall record the active status of the certification in the practitioner database maintained by the department.

12VAC35-225-500. Termination of certification.

A. The department shall terminate an early intervention practitioner's early intervention certification under the following circumstances:

1. The practitioner's discipline-specific license, certification, or endorsement has been suspended, revoked, or otherwise terminated by the appropriate Virginia health regulatory board or other Virginia entity exercising appropriate authority over the practitioner's discipline-specific license, certification, or endorsement;

2. The practitioner, after a year, fails to comply with the recertification requirements set forth in this chapter; or

3. The practitioner fails to comply with his signed assurance that he will comply with all federal and state early intervention requirements.

B. The department shall notify the early intervention practitioner in writing of the date of and reason for termination and that the practitioner has been removed from the practitioner database maintained by the department.

12VAC35-225-510. Reconsideration of decision to deny or terminate certification.

A. In the event that the early intervention practitioner disagrees with the determination to deny or terminate certification, he may request reconsideration from the commissioner. The request shall be made in writing within 30 days of the date of the written notice of denial or termination and may include relevant additional information or documentation to support the request.

B. The commissioner shall review the request for reconsideration and information presented and issue a decision in writing within 30 business days following receipt of the request. The decision of the commissioner shall be a final case decision that may be appealed under the Virginia Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia).

Part X

Comprehensive System of Personnel Development

12VAC35-225-520. Comprehensive system of personnel development requirements.

A. The department shall ensure a comprehensive system of personnel development that includes the following:

1. Training of paraprofessionals and the training of primary referral sources with respect to the basic components of early intervention services available in Virginia;

2. Training local lead agencies and early intervention service providers to implement innovative strategies and activities for the recruitment and retention of early intervention service practitioners and service providers;

3. Promoting the preparation of early intervention practitioners and service providers who are fully and appropriately qualified to provide early intervention services; and

4. Training local lead agencies and early intervention practitioners and service providers to coordinate transition services for children with disabilities who are transitioning from the early intervention system under Part C to a preschool program under § 619 of the Individuals with Disabilities Education Act, Head Start, Early Head Start, or another appropriate program.

B. The department shall establish and maintain an integrated training collaborative that includes university faculty, parents, early intervention service providers, and state early intervention professional development specialists to develop and implement professional development opportunities, materials, and resources on evidence-based practices for early intervention practitioners and service providers, families, university students, paraprofessionals, and primary referral sources.

C. The department shall use a variety of mechanisms to ensure awareness about and access to professional development, support, and resources, including statewide conferences and meetings, regional and local training activities, web-based training modules and resources, a written monthly update listing available resources and training, and teleconference and webinar capabilities.

D. The department shall support recruiting and retaining early intervention practitioners and service providers.

Part XI
Lead Agency Oversight Responsibilities

12VAC35-225-530. Lead agency monitoring and supervision.

A. The department shall monitor implementation of and enforce the requirements under Part C, make determinations annually about the performance of each local early intervention system, and report annually to the public on the performance of Virginia and of each local early intervention system within 120 days of submitting Virginia's annual performance report to the U.S. Department of Education.

B. The primary focus of monitoring activities shall be on improving early intervention results and functional outcomes for all children with disabilities and their families and ensuring that local early intervention systems meet the requirements under Part C.

C. The department shall use quantifiable indicators and, as needed, qualitative indicators to measure performance in providing early intervention services in natural environments, child find, effective monitoring, the use of mediation, and transition services.

D. The local lead agency and early intervention service providers shall cooperate fully with the department and shall provide all information requested by the department or its designee to monitor local performance and compliance with applicable state and federal regulations.

E. The department shall ensure that when it identifies noncompliance, the noncompliance is corrected as soon as possible and in no case later than one year after the noncompliance was identified.

F. If a local early intervention system is determined to need assistance for two or more consecutive years, need intervention, or need substantial intervention in meeting the requirements under Part C, or if the local early intervention system fails to correct noncompliance within one year of identification, then the department shall enforce the requirements under Part C using one or more enforcement actions that may include the following:

1. Technical assistance;

2. Imposing conditions on the local early intervention system's funding;

3. Requiring the development and implementation of an improvement plan; or

4. Withholding funds in whole or in part.

12VAC35-225-540. Data collection and reporting.

A. The department shall collect, compile, and report timely, accurate, valid, and reliable data as needed to meet the data collection requirements of the U.S. Department of Education and the Virginia General Assembly.

B. The department shall not report any data that would result in the disclosure of personally identifiable information about individual children.

VA.R. Doc. No. R15-3889; Filed December 15, 2014, 2:51 p.m.

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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 pursuant to § 2.2-4002 A 4 of the Code of Virginia.

Title of Regulation: **13VAC10-180. Rules and Regulations for Allocation of Low-Income Housing Tax Credits (amending 13VAC10-180-10, 13VAC10-180-50, 13VAC10-180-60).**

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

Effective Date: January 1, 2015.

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

Summary:

The amendments (i) replace the definition of "revitalization area" with the definition of such term contained in the Virginia Housing Development Authority Act; (ii) reduce the points awarded to developments located in revitalization areas; (iii) remove the point category for developments located in a qualified census tract because these developments automatically meet the revised definition of revitalization area; (iv) provide that maximum cost limits for developments do not include costs of installing electrical and plumbing hook-ups for dehumidification systems up to a maximum for such costs; (v) reduce the percentage of units required to be set aside

at more restrictive rent or income limits to receive maximum points for imposing more restrictive limits; (vi) add a point category for developments applying for both 4.0% and 9.0% credits; (vii) in the noncompetitive disability pool, reduce the minimum percentage of units to be marketed to people with disabilities required to earn points and, for developments receiving federal Housing and Urban Development Section 811 funding, create a minimum and maximum percentage of units to be marketed to people with disabilities required to earn points; (viii) add an additional point category for certain developments giving first preference to persons with intellectual or developmental disabilities; (ix) increase points for proximity to certain forms of public transportation for the Tidewater Metropolitan Statistical Area pool; (x) effective January 1, 2016, eliminate the point category for evidence of proper zoning and make such documentation a mandatory item; (xi) allow points for donated land or below market rate land leases in the subsidized funding point category; and (xii) make other miscellaneous administrative clarification changes.

13VAC10-180-10. Definitions.

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

"Applicant" means an applicant for credits under this chapter and also means the owner of the development to whom the credits are allocated.

"Credits" means the low-income housing tax credits as described in § 42 of the IRC.

"Elderly housing" means any development intended to provide housing for elderly persons as an exemption to the provisions regarding familial status under the United States Fair Housing Act (42 USC § 3601 et seq.).

"IRC" means the Internal Revenue Code of 1986, as amended, and the rules, regulations, notices and other official pronouncements promulgated thereunder.

"IRS" means the Internal Revenue Service.

"Low-income housing units" means those units ~~which~~ that are defined as "low income units" under § 42 of the IRC.

"Low-income jurisdiction" means any city or county in the Commonwealth with an area median income at or below the Virginia nonmetro area median income established by the U.S. Department of Housing and Urban Development (~~"~~HUD~~"~~).

"Principal" means any person (including any individual, joint venture, partnership, limited liability company, corporation, nonprofit organization, trust, or any other public or private entity) that (i) with respect to the proposed development will own or participate in the ownership of the proposed development or (ii) with respect to an existing [~~multi-family~~ multifamily] rental project has owned or participated in the ownership of such project, all as more fully described hereinbelow. The person who is the owner of the proposed development or multifamily rental project is considered a principal. In determining whether any other person is a principal, the following guidelines shall govern: (i) in the case of a partnership that is a principal (whether as the owner or otherwise), all general partners are also considered principals, regardless of the percentage interest of the general partner; (ii) in the case of a public or private corporation or organization or governmental entity that is a principal (whether as the owner or otherwise), principals also include the president, vice president, secretary, and treasurer and other officers who are directly responsible to the board of directors or any equivalent governing body, as well as all directors or other members of the governing body and any stockholder having a 25% or more interest; (iii) in the case of a limited liability company that is a principal (whether as the owner or otherwise), all members are also considered principals, regardless of the percentage interest of the member; (iv) in the case of a trust that is a principal (whether as the owner or otherwise), all persons having a 25% or more beneficial ownership interest in the assets of such trust; (v) in the case of any other person that is a principal (whether as the owner or otherwise), all persons having a 25% or more ownership interest in such other person are also considered principals; and (vi) any person that directly or indirectly controls, or has the power to control, a principal shall also be considered a principal.

"Qualified application" means a written request for tax credits ~~which~~ that is submitted on a form or forms prescribed or approved by the executive director together with all documents required by the authority for submission and meets all minimum scoring requirements.

"Qualified low-income buildings" or "qualified low-income development" means the buildings or development ~~which~~ that meets the applicable requirements in § 42 of the IRC to qualify for an allocation of credits thereunder.

~~"Revitalization area" means any area for which the chief executive officer (or the equivalent) of the local jurisdiction in which the development is to be located certifies as follows: (i) either (a) the area is blighted, deteriorated, deteriorating or, if not rehabilitated, likely to deteriorate by reason that the buildings, improvements or other facilities in such area are subject to one or more of the following conditions: dilapidation, obsolescence, overcrowding, inadequate ventilation, light or sanitation, excessive land coverage, deleterious land use, or faulty or inadequate design, quality or condition or (b) the industrial, commercial or other economic development of such area will benefit the city or county but such area lacks the housing needed to induce manufacturing, industrial, commercial, governmental, educational, entertainment, community development, healthcare or nonprofit enterprises or undertakings to locate or remain in such area; and (ii) private enterprise and investment are not reasonably expected, without assistance, to produce the construction or rehabilitation of decent, safe and sanitary~~

~~housing and supporting facilities that will meet the needs of low and moderate income persons and families in such area and will induce other persons and families to live within such area and thereby create a desirable economic mix of residents in such area. The area within a redevelopment project, conservation project, or rehabilitation district established by the city or county pursuant to Chapter 1 (§ 36-1 et seq.) of Title 36 of the Code of Virginia shall be deemed a revitalization area without any such certification. Any such revitalization area must either (i) include discussions from the locality of the type of developments that will be encouraged, the potential sources of funding, and services to be offered in the area; or (ii) be subject to a plan using Hope VI funds from HUD. A comprehensive plan does not qualify as certification of a revitalization area.~~

13VAC10-180-50. Application.

Prior to submitting an application for reservation, applicants shall submit on such form as required by the executive director, the letter for authority signature by which the authority shall notify the chief executive officers (or the equivalent) of the local jurisdictions in which the developments are to be located to provide such officers a reasonable opportunity to comment on the developments.

Application for a reservation of credits shall be commenced by filing with the authority an application, on such form or forms as the executive director may from time to time prescribe or approve, together with such documents and additional information (including, without limitation, a market study that shows adequate demand for the housing units to be produced by the applicant's proposed development) as may be requested by the authority in order to comply with the IRC and this chapter and to make the reservation and allocation of the credits in accordance with this chapter. The executive director may reject any application from consideration for a reservation or allocation of credits if in such application the applicant does not provide the proper documentation or information on the forms prescribed by the executive director.

All sites in an application for a scattered site development may only serve one primary market area. If the executive director determines that the sites subject to a scattered site development are served by different primary market areas, separate applications for credits must be filed for each primary market area in which scattered sites are located within the deadlines established by the executive director.

The application should include a breakdown of sources and uses of funds sufficiently detailed to enable the authority to ascertain what costs will be incurred and what will comprise the total financing package, including the various subsidies and the anticipated syndication or placement proceeds that will be raised. The following cost information, if applicable, needs to be included in the application to determine the feasible credit amount: site acquisition costs, site preparation costs, construction costs, construction contingency, general contractor's overhead and profit, architect and engineer's fees, permit and survey fees, insurance premiums, real estate taxes during construction, title and recording fees, construction period interest, financing fees, organizational costs, rent-up and marketing costs, accounting and auditing costs, working capital and operating deficit reserves, syndication and legal fees, development fees, and other costs and fees. All applications seeking credits for rehabilitation of existing units must provide for contractor construction costs of at least $10,000 per unit for developments financed with tax-exempt bonds and $15,000 per unit for all other developments.

Any application that exceeds the cost limits set forth below in subdivisions 1, 2, and 3 shall be rejected from further consideration hereunder and shall not be eligible for any reservation or allocation of credits.

1. Inner Northern Virginia. The Inner Northern Virginia region shall consist of Arlington County, Fairfax County, City of Alexandria, City of Fairfax, and City of Falls Church. The total development cost of proposed developments in the Inner Northern Virginia region may not exceed (i) for new construction or adaptive reuse: $335,475 per unit plus up to an additional $37,275 per unit if the proposed development contains underground or structured parking for each unit or (ii) for acquisition/rehabilitation: $292,875 per unit.

2. Prince William County, Loudoun County, and Fauquier County. The total development cost of proposed developments in Prince William County, Loudoun County, and Fauquier County may not exceed (i) for new construction or adaptive reuse: $249,210 per unit or (ii) for acquisition/rehabilitation: $175,725 per unit.

3. Balance of state. The total development cost of proposed developments in the balance of the state may not exceed (i) for new construction or adaptive reuse: $186,375 per unit or (ii) for acquisition/rehabilitation: $143,775 per unit.

Costs, subject to a per unit limit set by the executive director, attributable to equipping units with electrical and plumbing hook-ups for dehumidification systems will not be included in the calculation of the above per unit cost limits.

The cost limits in subdivisions 1, 2, and 3 above are 2012 fourth quarter base amounts. The cost limits shall be adjusted annually beginning in the fourth quarter of 2013 by the authority in accordance with Marshall & Swift cost factors for such quarter, and the adjusted limits will be indicated on the application form, instructions, or other communication available to the public.

Each application shall include plans and specifications or, in the case of rehabilitation for which plans will not be used, a unit-by-unit work write-up for such rehabilitation with certification in such form and from such person satisfactory to the executive director as to the completion of such plans or specifications or work write-up.

Each application shall include evidence of (i) sole fee simple ownership of the site of the proposed development by the applicant, (ii) lease of such site by the applicant for a term exceeding the compliance period (as defined in the IRC) or for such longer period as the applicant represents in the application that the development will be held for occupancy by low-income persons or families or (iii) right to acquire or lease such site pursuant to a valid and binding written option or contract between the applicant and the fee simple owner of such site for a period extending at least four months beyond any application deadline established by the executive director, provided that such option or contract shall have no conditions within the discretion or control of such owner of such site. Any contract for the acquisition of a site with existing residential property may not require an empty building as a condition of such contract, unless relocation assistance is provided to displaced households, if any, at such level required by the authority. A contract that permits the owner to continue to market the property, even if the applicant has a right of first refusal, does not constitute the requisite site control required in clause (iii) above. No application shall be considered for a reservation or allocation of credits unless such evidence is submitted with the application and the authority determines that the applicant owns, leases or has the right to acquire or lease the site of the proposed development as described in the preceding sentence. In the case of acquisition and rehabilitation of developments funded by Rural Development of the U.S. Department of Agriculture (Rural Development), any site control document subject to approval of the partners of the seller does not need to be approved by all partners of the seller if the general partner of the seller executing the site control document provides (i) an attorney's opinion that such general partner has the authority to enter into the site control document and such document is binding on the seller or (ii) a letter from the existing syndicator indicating a willingness to secure the necessary partner approvals upon the reservation of credits.

Effective January 1, 2016, each application shall include written evidence satisfactory to the authority (i) of proper zoning or special use permit for such site or (ii) that no zoning requirements or special use permits are applicable.

Each application shall include, in a form or forms required by the executive director, a certification of previous participation listing all developments receiving an allocation of tax credits under § 42 of the IRC in which the principal or principals have or had an ownership or participation interest, the location of such developments, the number of residential units and low-income housing units in such developments and such other information as more fully specified by the executive director. Furthermore, for any such development, the applicant must indicate whether the appropriate state housing credit agency has ever filed a Form 8823 with the IRS reporting noncompliance with the requirements of the IRC and that such noncompliance had not been corrected at the time of the filing of such Form 8823. The executive director may reject any application from consideration for a reservation or allocation of credits unless the above information is submitted with the application. If, after reviewing the above information or any other information available to the authority, the executive director determines that the principal or principals do not have the experience, financial capacity and predisposition to regulatory compliance necessary to carry out the responsibilities for the acquisition, construction, ownership, operation, marketing, maintenance and management of the proposed development or the ability to fully perform all the duties and obligations relating to the proposed development under law, regulation and the reservation and allocation documents of the authority or if an applicant is in substantial noncompliance with the requirements of the IRC, the executive director may reject applications by the applicant. No application will be accepted from any applicant with a principal that has or had an ownership or participation interest in a development at the time the authority reported such development to the IRS as no longer in compliance and no longer participating in the federal low-income housing tax credit program.

Each application shall include, in a form or forms required by the executive director, a certification that the design of the proposed development meets all applicable amenity and design requirements required by the executive director for the type of housing to be provided by the proposed development.

The application should include pro forma financial statements setting forth the anticipated cash flows during the credit period as defined in the IRC. The application shall include a certification by the applicant as to the full extent of all federal, state and local subsidies ~~which~~ that apply (or ~~which~~ that the applicant expects to apply) with respect to each building or development. The executive director may also require the submission of a legal opinion or other assurances satisfactory to the executive director as to, among other things, compliance of the proposed development with the IRC and a certification, together with an opinion of an independent certified public accountant or other assurances satisfactory to the executive director, setting forth the calculation of the amount of credits requested by the application and certifying, among other things, that under the existing facts and circumstances the applicant will be eligible for the amount of credits requested.

Each applicant shall commit in the application to provide relocation assistance to displaced households, if any, at such level required by the executive director. Each applicant shall commit in the application to use a property management company certified by the executive director to manage the proposed development.

If an applicant submits an application for reservation or allocation of credits that contains a material misrepresentation or fails to include information regarding developments involving the applicant that have been determined to be out of compliance with the requirements of the IRC, the executive

director may reject the application or stop processing such application upon discovery of such misrepresentation or noncompliance and may prohibit such applicant from submitting applications for credits to the authority in the future.

In any situation in which the executive director deems it appropriate, he may treat two or more applications as a single application. Only one application may be submitted for each location.

The executive director may establish criteria and assumptions to be used by the applicant in the calculation of amounts in the application, and any such criteria and assumptions may be indicated on the application form, instructions or other communication available to the public.

The executive director may prescribe such deadlines for submission of applications for reservation and allocation of credits for any calendar year as he shall deem necessary or desirable to allow sufficient processing time for the authority to make such reservations and allocations. If the executive director determines that an applicant for a reservation of credits has failed to submit one or more mandatory attachments to the application by the reservation application deadline, he may allow such applicant an opportunity to submit such attachments within a certain time established by the executive director with a 10-point scoring penalty per item.

After receipt of the applications, if necessary, the authority shall notify the chief executive officers (or the equivalent) of the local jurisdictions in which the developments are to be located and shall provide such officers a reasonable opportunity to comment on the developments.

The development for which an application is submitted may be, but shall not be required to be, financed by the authority. If any such development is to be financed by the authority, the application for such financing shall be submitted to and received by the authority in accordance with its applicable rules and regulations.

The authority may consider and approve, in accordance herewith, both the reservation and the allocation of credits to buildings or developments ~~which~~ that the authority may own or may intend to acquire, construct and/or rehabilitate.

13VAC10-180-60. Review and selection of applications; reservation of credits.

The executive director may divide the amount of credits into separate pools and each separate pool may be further divided into separate tiers. The division of such pools and tiers may be based upon one or more of the following factors: geographical areas of the state; types or characteristics of housing, construction, financing, owners, occupants, or source of credits; or any other factors deemed appropriate by him to best meet the housing needs of the Commonwealth.

An amount, as determined by the executive director, not less than 10% of the Commonwealth's annual state housing credit ceiling for credits, shall be available for reservation and allocation to buildings or developments with respect to which the following requirements are met:

1. A "qualified nonprofit organization" (as described in § 42(h)(5)(C) of the IRC) ~~which~~ that is authorized to do business in Virginia and is determined by the executive director, on the basis of such relevant factors as he shall consider appropriate, to be substantially based or active in the community of the development and is to materially participate (regular, continuous and substantial involvement as determined by the executive director) in the development and operation of the development throughout the "compliance period" (as defined in § 42(i)(1) of the IRC); and

2. (i) The "qualified nonprofit organization" described in the preceding subdivision 1 is to own (directly or through a partnership), prior to the reservation of credits to the buildings or development, all of the general partnership interests of the ownership entity thereof; (ii) the executive director of the authority shall have determined that such qualified nonprofit organization is not affiliated with or controlled by a for-profit organization; (iii) the executive director of the authority shall have determined that the qualified nonprofit organization was not formed by one or more individuals or for-profit entities for the principal purpose of being included in any nonprofit pools (as defined below) established by the executive director, and (iv) the executive director of the authority shall have determined that no staff member, officer or member of the board of directors of such qualified nonprofit organization will materially participate, directly or indirectly, in the proposed development as a for-profit entity.

In making the determinations required by the preceding subdivision 1 and clauses (ii), (iii) and (iv) of subdivision 2 of this section, the executive director may apply such factors as he deems relevant, including, without limitation, the past experience and anticipated future activities of the qualified nonprofit organization, the sources and manner of funding of the qualified nonprofit organization, the date of formation and expected life of the qualified nonprofit organization, the number of paid staff members and volunteers of the qualified nonprofit organization, the nature and extent of the qualified nonprofit organization's proposed involvement in the construction or rehabilitation and the operation of the proposed development, the relationship of the staff, directors or other principals involved in the formation or operation of the qualified nonprofit organization with any persons or entities to be involved in the proposed development on a for-profit basis, and the proposed involvement in the construction or rehabilitation and operation of the proposed development by any persons or entities involved in the proposed development on a for-profit basis. The executive director may include in the application of the foregoing factors any other nonprofit organizations ~~which~~ that, in his

determination, are related (by shared directors, staff or otherwise) to the qualified nonprofit organization for which such determination is to be made.

For purposes of the foregoing requirements, a qualified nonprofit organization shall be treated as satisfying such requirements if any qualified corporation (as defined in § 42(h)(5)(D)(ii) of the IRC) in which such organization (by itself or in combination with one or more qualified nonprofit organizations) holds 100% of the stock satisfies such requirements.

The applications shall include such representations and warranties and such information as the executive director may require in order to determine that the foregoing requirements have been satisfied. In no event shall more than 90% of the Commonwealth's annual state housing credit ceiling for credits be available for developments other than those satisfying the preceding requirements. The executive director may establish such pools (nonprofit pools) of credits as he may deem appropriate to satisfy the foregoing requirement. If any such nonprofit pools are so established, the executive director may rank the applications therein and reserve credits to such applications before ranking applications and reserving credits in other pools, and any such applications in such nonprofit pools not receiving any reservations of credits or receiving such reservations in amounts less than the full amount permissible hereunder (because there are not enough credits then available in such nonprofit pools to make such reservations) shall be assigned to such other pool as shall be appropriate hereunder; provided, however, that if credits are later made available (pursuant to the IRC or as a result of either a termination or reduction of a reservation of credits made from any nonprofit pools or a rescission in whole or in part of an allocation of credits made from such nonprofit pools or otherwise) for reservation and allocation by the authority during the same calendar year as that in which applications in the nonprofit pools have been so assigned to other pools as described above, the executive director may, in such situations, designate all or any portion of such additional credits for the nonprofit pools (or for any other pools as he shall determine) and may, if additional credits have been so designated for the nonprofit pools, reassign such applications to such nonprofit pools, rank the applications therein and reserve credits to such applications in accordance with the IRC and this chapter. In the event that during any round (as authorized hereinbelow) of application review and ranking the amount of credits reserved within such nonprofit pools is less than the total amount of credits made available therein, the executive director may either (i) leave such unreserved credits in such nonprofit pools for reservation and allocation in any subsequent round or rounds or (ii) redistribute, to the extent permissible under the IRC, such unreserved credits to such other pool or pools as the executive director shall designate reservations therefore in the full amount permissible hereunder (which applications shall hereinafter be referred to as "excess qualified applications") or (iii) carry over such unreserved credits to the next succeeding calendar year for the inclusion in the state housing credit ceiling (as defined in § 42(h)(3)(C) of the IRC) for such year. Notwithstanding anything to the contrary herein, no reservation of credits shall be made from any nonprofit pools to any application with respect to which the qualified nonprofit organization has not yet been legally formed in accordance with the requirements of the IRC. In addition, no application for credits from any nonprofit pools or any combination of pools may receive a reservation or allocation of annual credits in an amount greater than $750,000 unless credits remain available in such nonprofit pools after all eligible applications for credits from such nonprofit pools receive a reservation of credits.

Notwithstanding anything to the contrary herein, applicants relying on the experience of a local housing authority for developer experience points described hereinbelow and/or using Hope VI funds from HUD in connection with the proposed development shall not be eligible to receive a reservation of credits from any nonprofit pools.

The authority shall review each application, and, based on the application and other information available to the authority, shall assign points to each application as follows:

1. Readiness.

a. Written evidence satisfactory to the authority of unconditional approval by local authorities of the plan of development or site plan for the proposed development or that such approval is not required. (40 points; applicants receiving points under this subdivision 1 a are not eligible for points under subdivision 5 a below)

b. ~~Written~~ For applications submitted prior to January 1, 2016, written evidence satisfactory to the authority (i) of proper zoning or special use permit for such site or (ii) that no zoning requirements or special use permits are applicable. (40 points)

2. Housing needs characteristics.

a. Submission of the form prescribed by the authority with any required attachments, providing such information necessary for the authority to send a letter addressed to the current chief executive officer (or the equivalent) of the locality in which the proposed development is located, soliciting input on the proposed development from the locality within the deadlines established by the executive director. (minus 50 points for failure to make timely submission)

b. A letter in response to its notification to the chief executive officer of the locality in which the proposed development is to be located opposing the allocation of credits to the applicant for the development. In any such letter, the chief executive officer must certify that the proposed development is not consistent with current zoning or other applicable land use regulations. Any such letter must also be accompanied by a legal opinion of the

locality's attorney opining that the locality's opposition to the proposed development does not have a discriminatory intent or a discriminatory effect (as defined in 24 CFR 100.500(a)) that is not supported by a legally sufficient justification (as defined in 24 CFR 100.500(b)) in violation of the Fair Housing Act (Title VIII of the Civil Rights Act of 1968, as amended) and the HUD implementing regulations. (minus 25 points)

~~c. Documentation in a form approved by the authority from the chief executive officer (or the equivalent) of the local jurisdiction in which the development is to be located (including the certification described in the definition of revitalization area in 13VAC10-180-10) that the area in which the proposed development is to be located is a revitalization area and the proposed development is an integral part of the local government's plan for revitalization of the area. (30 points)~~

~~d. If the proposed development is located in a qualified census tract as defined in § 42(d)(5)(C)(ii) of the IRC and is in a revitalization area. (5 points)~~

~~e.~~ c. Any proposed development that is to be located in a revitalization area meeting the requirements of § 36-55.30:2 A of the Code of Virginia. (10 points)

d. Commitment by the applicant for any development without section 8 project-based assistance to give leasing preference to individuals and families (i) on public housing waiting lists maintained by the local housing authority operating in the locality in which the proposed development is to be located and notification of the availability of such units to the local housing authority by the applicant or (ii) on section 8 (as defined in 13VAC10-180-90) waiting lists maintained by the local or nearest section 8 administrator for the locality in which the proposed development is to be located and notification of the availability of such units to the local section 8 administrator by the applicant. (10 points; Applicants receiving points under this subdivision may not require an annual minimum income requirement for prospective tenants that exceeds the greater of $3,600 or 2.5 times the portion of rent to be paid by such tenants.)

~~f.~~ e. Any of the following: (i) firm financing commitment(s) from the local government, local housing authority, Federal Home Loan Bank affordable housing funds, Virginia Housing Trust Fund, funding from VOICE for projects located in Prince William County and donations from unrelated private foundations that have filed an IRS Form 990 (or a variation of such form) or Rural Development for a below-market rate loan or grant; (ii) a resolution passed by the locality in which the proposed development is to be located committing such financial support to the development in a form approved by the authority; ~~or~~ (iii) a commitment to donate land, buildings or tap fee waivers from the local government~~.~~; or (iv) a commitment to donate land (including a below market rate land lease) from an entity that is not a principal in the applicant (the donor being the grantee of a right of first refusal or purchase option, with no ownership interest in the applicant, shall not make the donor a principal in the applicant). (The amount of such financing ~~or~~, dollar value of local support, or value of donated land (including a below market rate land lease) will be determined by the executive director and divided by the total development sources of funds and the proposed development receives two points for each percentage point up to a maximum of 40 points.)

~~g.~~ f. Any development subject to (i) HUD's Section 8 or Section 236 programs or (ii) Rural Development's 515 program, at the time of application. (20 points, unless the applicant is, or has any common interests with, the current owner, directly or indirectly, the application will only qualify for these points if the applicant waives all rights to any developer's fee and any other fees associated with the acquisition and rehabilitation (or rehabilitation only) of the development unless permitted by the executive director for good cause.)

~~h.~~ g. Any development receiving (i) a real estate tax abatement on the increase in the value of the development or (ii) new project-based subsidy from HUD or Rural Development for the greater of five units or 10% of the units of the proposed development. (10 points)

~~i.~~ h. Any proposed elderly development located in a census tract that has less than a 10% poverty rate (based upon Census Bureau data) with no other elderly tax credit units in such census tract. (25 points)

~~j.~~ i. Any proposed family development located in a census tract that has less than a 10% poverty rate (based upon Census Bureau data) with no other family tax credit units in such census tract. (25 points)

~~k.~~ j. Any proposed development listed in the top 25 developments identified by Rural Development as high priority for rehabilitation at the time the application is submitted to the authority. (15 points)

~~l.~~ k. Any proposed new construction development (including adaptive re-use and rehabilitation that creates additional rental space) located in a pool identified by the authority as a pool with little or no increase in rent-burdened population. (up to minus 20 points, depending upon the portion of the development that is additional rental space, in all pools except the at-large pool, 0 points in the at-large pool. The executive director may make exceptions in the following circumstances:

(1) Specialized types of housing designed to meet special needs that cannot readily be addressed utilizing existing residential structures;

(2) Housing designed to serve as a replacement for housing being demolished through redevelopment; or

(3) Housing that is an integral part of a neighborhood revitalization project sponsored by a local housing authority.)

~~m.~~ l. Any proposed new construction development (including adaptive re-use and rehabilitation that creates additional rental space) that is located in a pool identified by the authority as a pool with an increasing rent-burdened population. (up to 20 points, depending upon the portion of the development that is additional rental space, in all pools except the at-large pool, 0 points in the at-large pool)

3. Development characteristics.

a. Evidence satisfactory to the authority documenting the quality of the proposed development's amenities as determined by the following:

(1) The following points are available for any application:

(a) If a community/meeting room with a minimum of 749 square feet is provided. (5 points)

(b) If the exterior walls are constructed using the following materials:

(i) Brick or other similar low-maintenance material approved by the authority (as indicated on the application form, instructions, or other communication available to the public) covering 30% or more of the exterior walls. (10 points) and

(ii) If subdivision (b) (i) above is met, an additional one-fifth point for each percent of exterior wall brick or other similar low-maintenance material approved by the authority (as indicated on the application form, instructions, or other communication available to the public) in excess of 30%. (maximum 10 points) and

(iii) If subdivision (b) (i) above is met, an additional one-tenth point for each percent of exterior wall covered by fiber-cement board. (maximum 7 points)

(c) If all kitchen and laundry appliances (except range hoods) meet the EPA's Energy Star qualified program requirements. (5 points)

(d) If all the windows and glass doors meet the EPA's Energy Star qualified program requirements. (5 points)

(e) If every unit in the development is heated and cooled with either (i) heat pump equipment with both a SEER rating of 15.0 or more and a HSPF rating of 8.5 or more or (ii) air conditioning equipment with a SEER rating of 15.0 or more, combined with a gas furnace with an AFUE rating of 90% or more. (10 points)

(f) If the water expense is submetered (the tenant will pay monthly or bimonthly bill). (5 points)

(g) If each bathroom contains only WaterSense labeled faucets and showerheads. (2 points)

(h) If each unit is provided with the necessary infrastructure for high-speed cable, DSL or wireless Internet service. (1 point)

(i) If all the water heaters have an energy factor greater than or equal to 67% for gas water heaters or greater than or equal to 93% for electric water heaters; or any centralized commercial system that has an efficiency performance rating equal to or greater than 95%, or any solar thermal system that meets at least 60% of the development's domestic hot water load. (5 points)

(j) If each bathroom is equipped with a WaterSense labeled toilet. (2 points)

(k) For new construction only, if each full bathroom is equipped with EPA Energy Star qualified bath vent fans. (2 points)

(l) If the development has or the application provides for installation of continuous R-3 or higher wall sheathing insulation. (5 points)

(m) If all cooking surfaces are equipped with fire prevention or suppression features that meet the authority's requirements (as indicated on the application form, instructions, or other communication available to the public). (2 points)

(2) The following points are available to applications electing to serve elderly tenants:

(a) If all cooking ranges have front controls. (1 point)

(b) If all units have an emergency call system. (3 points)

(c) If all bathrooms have an independent or supplemental heat source. (1 point)

(d) If all entrance doors to each unit have two eye viewers, one at 42 inches and the other at standard height. (1 point)

(3) If the structure is historic, by virtue of being listed individually in the National Register of Historic Places, or due to its location in a registered historic district and certified by the Secretary of the Interior as being of historical significance to the district, and the rehabilitation will be completed in such a manner as to be eligible for historic rehabilitation tax credits. (5 points)

b. Any development in which (i) the greater of five units or 10% of the units will be assisted by HUD project-based vouchers (as evidenced by the submission of a letter satisfactory to the authority from an authorized public housing authority (PHA) that the development meets all prerequisites for such assistance)~~,~~ or other form of documented and binding federal or state project-based rent subsidies ~~or equivalent assistance (approved by the executive director)~~ in order to ensure occupancy by extremely low-income persons; and (ii) the greater of five units or 10% of the units will conform to HUD regulations interpreting the accessibility requirements of § 504 of the Rehabilitation Act and be actively marketed

to persons with disabilities as defined in the Fair Housing Act in accordance with a plan submitted as part of the application for credits (all common space must also conform to HUD regulations interpreting the accessibility requirements of § 504 of the Rehabilitation Act, and all the units described in (ii) above must include roll-in showers and roll-under sinks and front control ranges, unless agreed to by the authority prior to the applicant's submission of its application). (50 points)

In addition, [~~subject to HUD granting the authority approval for the following prior to the effective date of the plan,~~ for] any development eligible for the preceding 50 points [~~having a marketing plan submitted as part of the application for credits containing~~, subject to appropriate federal approval, any applicant that commits to providing] a first preference on [~~the~~ its] waiting list for persons with an intellectual or developmental disability (ID/DD) as confirmed by the Virginia Department of Medical Assistance Services (DMAS) or Virginia Department of Behavioral Health and Developmental Services (DBHDS) for the greater of five units or 10% of the units. [~~(10~~ (25] points)

c. Any development in which the greater of five units or 10% of the units (i) have rents within HUD's Housing Choice Voucher (HCV) payment standard, (ii) conform to HUD regulations interpreting the accessibility requirements of § 504 of the Rehabilitation Act~~;~~, and ~~(ii)~~ (iii) are actively marketed to persons with disabilities as defined in the Fair Housing Act in accordance with a plan submitted as part of the application for credits (all common space must also conform to HUD regulations interpreting the accessibility requirements of § 504 of the Rehabilitation Act). (30 points)

d. Any development in which 5.0% of the units (i) conform to HUD regulations interpreting the accessibility requirements of § 504 of the Rehabilitation Act and (ii) are actively marketed to persons with disabilities as defined in the Fair Housing Act in accordance with a plan submitted as part of the application for credits. (15 points)

e. Any development located within one-half mile of an existing commuter rail, light rail or subway station or one-quarter mile of one or more existing public bus stops. (10 points, unless the development is located within the geographical area established by the executive director for a pool of credits for Northern Virginia or Tidewater Metropolitan Statistical Area (MSA), in which case, the development will receive 20 points if the development is ranked against other developments in such Northern Virginia or Tidewater MSA pool, 10 points if the development is ranked against other developments in any other pool of credits established by the executive director)

f. Any development for which the applicant agrees to obtain either (i) EarthCraft certification or (ii) U.S. Green Building Council LEED green-building certification prior to the issuance of an IRS Form 8609 with the proposed development's architect certifying in the application that the development's design will meet the criteria for such certification, provided that the proposed development's architect is on the authority's list of LEED/EarthCraft certified architects. (15 points for a LEED Silver development or EarthCraft certified development; 30 points for a LEED Gold development or EarthCraft Gold development; 45 points for a LEED Platinum development or EarthCraft Platinum development.) The executive director may, if needed, designate a proposed development as requiring an increase in credit in order to be financially feasible and such development shall be treated as if in a difficult development area as provided in the IRC for any applicant receiving 30 or 45 points under this subdivision, provided however, any resulting increase in such development's eligible basis shall be limited to 5.0% of the development's eligible basis for 30 points awarded under this subdivision and 10% for 45 points awarded under this subdivision of the development's eligible basis.

g. If units are constructed to include the authority's universal design features, provided that the proposed development's architect is on the authority's list of universal design certified architects. (15 points, if all the units in an elderly development meet this requirement; 15 points multiplied by the percentage of units meeting this requirement for nonelderly developments)

h. Any development in which the applicant proposes to produce less than 100 low-income housing units. (20 points for producing 50 low-income housing units or less, minus 0.4 points for each additional low-income housing unit produced down to 0 points for any development that produces 100 or more low-income housing units.)

i. [~~Any development in which the applicant will also make an application for credits based upon financing by tax-exempt bonds for a development located on the same or contiguous site. (30 points)~~ Any applicant for a development that, pursuant to a common plan of development, is part of a larger development located on the same or contiguous sites, financed in part by tax-exempt bonds. (20 points for tax-exempt bond financing of at least 30% of aggregate units, 30 points for tax-exempt bond financing of at least 40% of aggregate units, and 40 points for tax-exempt bond financing of at least 50% of aggregate units; such points being noncumulative)]

4. Tenant population characteristics. Commitment by the applicant to give a leasing preference to individuals and

families with children in developments that will have no more than 20% of its units with one bedroom or less. (15 points; plus 0.75 points for each percent of the low-income units in the development with three or more bedrooms up to an additional 15 points for a total of no more than 30 points)

5. Sponsor characteristics.

a. Evidence that the ~~principal or principals~~ controlling general partner or managing member of the controlling general partner or managing member for the proposed development have developed:

(1) As controlling general partner or managing member, (i) at least three tax credit developments that contain at least three times the number of housing units in the proposed development or (ii) at least six tax credit developments. (50 points) or

(2) At least three deals as a principal and have at least $500,000 in liquid assets. "Liquid assets" means cash, cash equivalents, and investments held in the name of the entity(s) and or person(s), including cash in bank accounts, money market funds, U.S. Treasury bills, and equities traded on the New York Stock Exchange or NASDAQ. Certain cash and investments will not be considered liquid assets, including but not limited to: (i) stock held in the applicant's own company or any closely held entity, (ii) investments in retirement accounts, (iii) cash or investments pledged as collateral for any liability, and (iv) cash in property accounts, including reserves. The authority will assess the financial capacity of the applicant based on its financial statements. The authority will accept financial statements audited, reviewed, or compiled by an independent certified public accountant. Only a balance sheet dated on or after December 31 of the year prior to the application deadline is required. The authority will accept a compilation report with or without full note disclosures. Supplementary schedules for all significant assets and liabilities may be required. Financial statements prepared in accordance with accounting principles generally accepted in the United States (U.S. GAAP) are preferred. Statements prepared in the income tax basis or cash basis must disclose that basis in the report. The authority reserves the right to verify information in the financial statements. (50 points) or

(3) As controlling general partner or managing member, at least one tax credit development that contains at least the number of housing units in the proposed development. (10 points)

Applicants receiving points under subdivision 5 a (1) and (2) above are not eligible for points under subdivision a of subdivision 1 Readiness, above.

b. Any applicant that includes a principal that was a principal in a development at the time the authority inspected such development and discovered a life-threatening hazard under HUD's Uniform Physical Condition Standards and such hazard was not corrected in the time frame established by the authority. (minus 50 points for a period of three years after the violation has been corrected)

c. Any applicant that includes a principal that was a principal in a development that either (i) at the time the authority reported such development to the IRS for noncompliance had not corrected such noncompliance by the time a Form 8823 was filed by the authority or (ii) remained out-of-compliance with the terms of its extended use commitment after notice and expiration of any cure period set by the authority. (minus 15 points for a period of three calendar years after the year the authority filed Form 8823 or expiration of such cure period, unless the executive director determines that such principal's attempts to correct such noncompliance was prohibited by a court, local government or governmental agency, in which case, no negative points will be assessed to the applicant, or 0 points, if the appropriate individual or individuals connected to the principal attend compliance training as recommended by the authority)

d. Any applicant that includes a principal that is or was a principal in a development that (i) did not build a development as represented in the application for credit (minus two times the number of points assigned to the item or items not built or minus 20 points for failing to provide a minimum building requirement, for a period of three years after the last Form 8609 is issued for the development, in addition to any other penalties the authority may seek under its agreements with the applicant), or (ii) has a reservation of credits terminated by the authority (minus 10 points a period of three years after the credits are returned to the authority).

e. Any applicant that includes a management company in its application that is rated unsatisfactory by the executive director or if the ownership of any applicant includes a principal that is or was a principal in a development that hired a management company to manage a tax credit development after such management company received a rating of unsatisfactory from the executive director during the compliance period and extended use period of such development. (minus 25 points)

f. Any applicant that includes a principal that was a principal in a development for which the actual cost of construction (as certified in the Independent Auditor's Report with attached Certification of Sources and Uses that is submitted in connection with the Owner's Application for IRS Form 8609) exceeded the applicable cost limit by 5.0% or more (minus 50 points for a period of three calendar years after December 31 of the year the cost certification is complete; provided, however, if the

Board of Commissioners determines that such overage was outside of the applicant's control based upon documented extenuating circumstances, no negative points will be assessed).

6. Efficient use of resources.

a. The percentage by which the total of the amount of credits per low-income housing unit (the "per unit credit amount") of the proposed development is less than the standard per unit credit amounts established by the executive director for a given unit type, based upon the number of such unit types in the proposed development. (200 points multiplied by the percentage by which the total amount of the per unit credit amount of the proposed development is less than the applicable standard per unit credit amount established by the executive director, negative points will be assessed using the percentage by which the total amount of the per unit credit amount of the proposed development exceeds the applicable standard per unit credit amount established by the executive director.)

b. The percentage by which the cost per low-income housing unit (the "per unit cost"), adjusted by the authority for location, of the proposed development is less than the standard per unit cost amounts established by the executive director for a given unit type, based upon the number of such unit types in the proposed development. (100 points multiplied by the percentage by which the total amount of the per unit cost of the proposed development is less than the applicable standard per unit cost amount established by the executive director; negative points will be assessed using the percentage by which the total amount of the per unit cost amount of the proposed development exceeds the applicable standard per unit cost amount established by the executive director.)

The executive director may use a standard per square foot credit amount and a standard per square foot cost amount in establishing the per unit credit amount and the per unit cost amount in subdivision 6 above. For the purpose of calculating the points to be assigned pursuant to such subdivision 6 above, all credit amounts shall include any credits previously allocated to the development.

7. Bonus points.

a. Commitment by the applicant to impose income limits on the low-income housing units throughout the extended use period (as defined in the IRC) below those required by the IRC in order for the development to be a qualified low-income development. Applicants receiving points under this subdivision a may not receive points under subdivision b below. (Up to 50 points, the product of (i) ~~62.5~~ 100 multiplied by (ii) the percentage of housing units in the proposed development both rent restricted to and occupied by households at or below 50% of the area median gross income; plus ~~1~~ one point for each percentage point of such housing units in the proposed development ~~which~~ that are further restricted to rents at or below 30% of 40% of the area median gross income up to an additional 10 points.)

b. Commitment by the applicant to impose rent limits on the low-income housing units throughout the extended use period (as defined in the IRC) below those required by the IRC in order for the development to be a qualified low-income development. Applicants receiving points under this subdivision b may not receive points under subdivision a above. (Up to 25 points, the product of (i) ~~31.25~~ 50 multiplied by (ii) the percentage of housing units in the proposed development rent restricted to households at or below 50% of the area median gross income; plus ~~1~~ one point for each percentage point of such housing units in the proposed development ~~which~~ that are further restricted to rents at or below 30% of 40% of the area median gross income up to an additional 10 points. Points for proposed developments in low-income jurisdictions shall be two times the points calculated in the preceding sentence, up to 50 points.)

c. Commitment by the applicant to maintain the low-income housing units in the development as a qualified low-income housing development beyond the 30-year extended use period (as defined in the IRC). Applicants receiving points under this subdivision c may not receive bonus points under subdivision d below. (40 points for a 10-year commitment beyond the 30-year extended use period or 50 points for a 20-year commitment beyond the 30-year extended use period.)

d. Participation by a local housing authority or qualified nonprofit organization (substantially based or active in the community with at least a 10% ownership interest in the general partnership interest of the partnership) and a commitment by the applicant to sell the proposed development pursuant to an executed, recordable option or right of first refusal to such local housing authority or qualified nonprofit organization or to a wholly owned subsidiary of such organization or authority, at the end of the 15-year compliance period, as defined by IRC, for a price not to exceed the outstanding debt and exit taxes of the for-profit entity. The applicant must record such option or right of first refusal immediately after the low-income housing commitment described in 13VAC10-180-70. Applicants receiving points under this subdivision d may not receive bonus points under subdivision c above. (60 points; plus ~~5~~ five points if the local housing authority or qualified nonprofit organization submits a homeownership plan satisfactory to the authority in which the local housing authority or qualified nonprofit organization commits to sell the units in the development to tenants.)

In calculating the points for subdivisions 7 a and b above, any units in the proposed development required by the

locality to exceed 60% of the area median gross income will not be considered when calculating the percentage of low-income units of the proposed development with incomes below those required by the IRC in order for the development to be a qualified low-income development, provided that the locality submits evidence satisfactory to the authority of such requirement.

After points have been assigned to each application in the manner described above, the executive director shall compute the total number of points assigned to each such application. Any application that is assigned a total number of points less than a threshold amount of 425 points (325 points for developments financed with tax-exempt bonds in such amount so as not to require under the IRC an allocation of credits hereunder) shall be rejected from further consideration hereunder and shall not be eligible for any reservation or allocation of credits.

During its review of the submitted applications, the authority may conduct its own analysis of the demand for the housing units to be produced by each applicant's proposed development. Notwithstanding any conclusion in the market study submitted with an application, if the authority determines that, based upon information from its own loan portfolio or its own market study, inadequate demand exists for the housing units to be produced by an applicant's proposed development, the authority may exclude and disregard the application for such proposed development.

The executive director may exclude and disregard any application ~~which~~ that he determines is not submitted in good faith or ~~which~~ that he determines would not be financially feasible.

Upon assignment of points to all of the applications, the executive director shall rank the applications based on the number of points so assigned. If any pools shall have been established, each application shall be assigned to a pool and, if any, to the appropriate tier within such pool and shall be ranked within such pool or tier, if any. The amount of credits made available to each pool will be determined by the executive director. Available credits will include unreserved per capita dollar amount credits from the current calendar year under § 42(h)(3)(C)(i) of the IRC, any unreserved per capita credits from previous calendar years, and credits returned to the authority prior to the final ranking of the applications and may include up to 40% of next calendar year's per capita credits as shall be determined by the executive director. Those applications assigned more points shall be ranked higher than those applications assigned fewer points. However, if any set-asides established by the executive director cannot be satisfied after ranking the applications based on the number of points, the executive director may rank as many applications as necessary to meet the requirements of such set-aside (selecting the highest ranked application, or applications, meeting the requirements of the set-aside) over applications with more points.

In the event of a tie in the number of points assigned to two or more applications within the same pool, or, if none, within the Commonwealth, and in the event that the amount of credits available for reservation to such applications is determined by the executive director to be insufficient for the financial feasibility of all of the developments described therein, the authority shall, to the extent necessary to fully utilize the amount of credits available for reservation within such pool or, if none, within the Commonwealth, select one or more of the applications with the highest combination of points from subdivision 7 above, and each application so selected shall receive (in order based upon the number of such points, beginning with the application with the highest number of such points) a reservation of credits. If two or more of the tied applications receive the same number of points from subdivision 7 above and if the amount of credits available for reservation to such tied applications is determined by the executive director to be insufficient for the financial feasibility of all the developments described therein, the executive director shall select one or more of such applications by lot, and each application so selected by lot shall receive (in order of such selection by lot) a reservation of credits.

For each application which may receive a reservation of credits, the executive director shall determine the amount, as of the date of the deadline for submission of applications for reservation of credits, to be necessary for the financial feasibility of the development and its viability as a qualified low-income development throughout the credit period under the IRC. In making this determination, the executive director shall consider the sources and uses of the funds, the available federal, state and local subsidies committed to the development, the total financing planned for the development as well as the investment proceeds or receipts expected by the authority to be generated with respect to the development, and the percentage of the credit dollar amount used for development costs other than the costs of intermediaries. He shall also examine the development's costs, including developer's fees and other amounts in the application, for reasonableness, and~~,~~ if he determines that such costs or other amounts are unreasonably high, he shall reduce them to amounts that he determines to be reasonable. The executive director shall review the applicant's projected rental income, operating expenses and debt service for the credit period. The executive director may establish such criteria and assumptions as he shall deem reasonable for the purpose of making such determination, including, without limitation, criteria as to the reasonableness of fees and profits and assumptions as to the amount of net syndication proceeds to be received (based upon such percentage of the credit dollar amount used for development costs, other than the costs of intermediaries, as the executive director shall determine to be reasonable for the proposed development), increases in the market value of the development, and increases in operating expenses, rental income and, in the case of applications

without firm financing commitments (as defined hereinabove) at fixed interest rates, debt service on the proposed mortgage loan. The executive director may, if he deems it appropriate, consider the development to be a part of a larger development. In such a case, the executive director may consider, examine, review and establish any or all of the foregoing items as to the larger development in making such determination for the development.

At such time or times during each calendar year as the executive director shall designate, the executive director shall reserve credits to applications in descending order of ranking within each pool and tier, if applicable, until either substantially all credits therein are reserved or all qualified applications therein have received reservations. (For the purpose of the preceding sentence, if there is not more than a de minimis amount, as determined by the executive director, of credits remaining in a pool after reservations have been made, "substantially all" of the credits in such pool shall be deemed to have been reserved.) The executive director may rank the applications within pools at different times for different pools and may reserve credits, based on such rankings, one or more times with respect to each pool. The executive director may also establish more than one round of review and ranking of applications and reservation of credits based on such rankings, and he shall designate the amount of credits to be made available for reservation within each pool during each such round. The amount reserved to each such application shall be equal to the lesser of (i) the amount requested in the application or (ii) an amount determined by the executive director, as of the date of application, to be necessary for the financial feasibility of the development and its viability as a qualified low-income development throughout the credit period under the IRC; provided, however, that in no event shall the amount of credits so reserved exceed the maximum amount permissible under the IRC.

Not more than 20% of the credits in any pool may be reserved to developments intended to provide elderly housing, unless the feasible credit amount, as determined by the executive director, of the highest ranked elderly housing development in any pool exceeds 20% of the credits in such pool, then such elderly housing development shall be the only elderly housing development eligible for a reservation of credits from such pool. However, if credits remain available for reservation after all eligible nonelderly housing developments receive a reservation of credits, such remaining credits may be made available to additional elderly housing developments. The above limitation of credits available for elderly housing shall not include elderly housing developments with project-based subsidy providing rental assistance for at least 20% of the units that are submitted as rehabilitation developments or assisted living facilities licensed under Chapter 17 (§ 63.2-1700 et seq.) of Title 63.2 of the Code of Virginia.

If the amount of credits available in any pool is determined by the executive director to be insufficient for the financial feasibility of the proposed development to which such available credits are to be reserved, the executive director may move the proposed development and the credits available to another pool. If any credits remain in any pool after moving proposed developments and credits to another pool, the executive director may for developments that meet the requirements of § 42(h)(1)(E) of the IRC only, reserve the remaining credits to any proposed development(s) scoring at or above the minimum point threshold established by this chapter without regard to the ranking of such application with additional credits from the Commonwealth's annual state housing credit ceiling for the following year in such an amount necessary for the financial feasibility of the proposed development, or developments. However, the reservation of credits from the Commonwealth's annual state housing credit ceiling for the following year shall be in the reasonable discretion of the executive director if he determines it to be in the best interest of the plan. In the event a reservation or an allocation of credits from the current year or a prior year is reduced, terminated, or ~~cancelled~~ canceled, the executive director may substitute such credits for any credits reserved from the following year's annual state housing credit ceiling.

In the event that during any round of application review and ranking the amount of credits reserved within any pools is less than the total amount of credits made available therein during such round, the executive director may either (i) leave such unreserved credits in such pools for reservation and allocation in any subsequent round or rounds or (ii) redistribute such unreserved credits to such other pool or pools as the executive director may designate or (iii) supplement such unreserved credits in such pools with additional credits from the Commonwealth's annual state housing credit ceiling for the following year for reservation and allocation~~,~~ if in the reasonable discretion of the executive director, it serves the best interest of the plan, or (iv) carry over such unreserved credits to the next succeeding calendar year for inclusion in the state housing credit ceiling (as defined in § 42(h)(3)(C) of the IRC) for such year.

Notwithstanding anything contained herein, the total amount of credits that may be awarded in any credit year after credit year 2001 to any applicant or to any related applicants for one or more developments shall not exceed 15% of Virginia's per capita dollar amount of credits for such credit year (the "credit cap"). However, if the amount of credits to be reserved in any such credit year to all applications assigned a total number of points at or above the threshold amount set forth above shall be less than Virginia's dollar amount of credits available for such credit year, then the authority's board of commissioners may waive the credit cap to the extent it deems necessary to reserve credits in an amount at least equal to such dollar amount of credits. Applicants shall be deemed to be related if any principal in a proposed development or any person or entity related to the applicant

or principal will be a principal in any other proposed development or developments. For purposes of this paragraph, a principal shall also include any person or entity who, in the determination of the executive director, has exercised or will exercise, directly or indirectly, substantial control over the applicant or has performed or will perform (or has assisted or will assist the applicant in the performance of), directly or indirectly, substantial responsibilities or functions customarily performed by applicants with respect to applications or developments. For the purpose of determining whether any person or entity is related to the applicant or principal, persons or entities shall be deemed to be related if the executive director determines that any substantial relationship existed, either directly between them or indirectly through a series of one or more substantial relationships (e.g., if party A has a substantial relationship with party B and if party B has a substantial relationship with party C, then A has a substantial relationship with both party B and party C), at any time within three years of the filing of the application for the credits. In determining in any credit year whether an applicant has a substantial relationship with another applicant with respect to any application for which credits were awarded in any prior credit year, the executive director shall determine whether the applicants were related as of the date of the filing of such prior credit year's application or within three years prior thereto and shall not consider any relationships or any changes in relationships subsequent to such date. Substantial relationships shall include, but not be limited to, the following relationships (in each of the following relationships, the persons or entities involved in the relationship are deemed to be related to each other): (i) the persons are in the same immediate family (including, without limitation, a spouse, children, parents, grandparents, grandchildren, brothers, sisters, uncles, aunts, nieces, and nephews) and are living in the same household; (ii) the entities have one or more common general partners or members (including related persons and entities), or the entities have one or more common owners that (by themselves or together with any other related persons and entities) have, in the aggregate, 5.0% or more ownership interest in each entity; (iii) the entities are under the common control (e.g., the same person or persons and any related persons serve as a majority of the voting members of the boards of such entities or as chief executive officers of such entities) of one or more persons or entities (including related persons and entities); (iv) the person is a general partner, member or employee in the entity or is an owner (by himself or together with any other related persons and entities) of 5.0% or more ownership interest in the entity; (v) the entity is a general partner or member in the other entity or is an owner (by itself or together with any other related persons and entities) of 5.0% or more ownership interest in the other entity; or (vi) the person or entity is otherwise controlled, in whole or in part, by the other person or entity. In determining compliance with the credit cap with respect to any application, the executive director may exclude any person or entity related to the applicant or to any principal in such applicant if the executive director determines that (i) such person or entity will not participate, directly or indirectly, in matters relating to the applicant or the ownership of the development to be assisted by the credits for which the application is submitted, (ii) such person or entity has no agreement or understanding relating to such application or the tax credits requested therein, and (iii) such person or entity will not receive a financial benefit from the tax credits requested in the application. A limited partner or other similar investor shall not be determined to be a principal and shall be excluded from the determination of related persons or entities unless the executive director shall determine that such limited partner or investor will, directly or indirectly, exercise control over the applicant or participate in matters relating to the ownership of the development substantially beyond the degree of control or participation that is usual and customary for limited partners or other similar investors with respect to developments assisted by the credits. If the award of multiple applications of any applicant or related applicants in any credit year shall cause the credit cap to be exceeded, such applicant or applicants shall, upon notice from the authority, jointly designate those applications for which credits are not to be reserved so that such limitation shall not be exceeded. Such notice shall specify the date by which such designation shall be made. In the absence of any such designation by the date specified in such notice, the executive director shall make such designation as he shall determine to best serve the interests of the program. Each applicant and each principal therein shall make such certifications, shall disclose such facts and shall submit such documents to the authority as the executive director may require to determine compliance with credit cap. If an applicant or any principal therein makes any misrepresentation to the authority concerning such applicant's or principal's relationship with any other person or entity, the executive director may reject any or all of such applicant's pending applications for reservation or allocation of credits, may terminate any or all reservations of credits to the applicant, and may prohibit such applicant, the principals therein and any persons and entities then or thereafter having a substantial relationship (in the determination of the executive director as described above) with the applicant or any principal therein from submitting applications for credits for such period of time as the executive director shall determine.

Within a reasonable time after credits are reserved to any applicants' applications, the executive director shall notify each applicant for such reservations of credits either of the amount of credits reserved to such applicant's application (by issuing to such applicant a written binding commitment to allocate such reserved credits subject to such terms and conditions as may be imposed by the executive director therein, by the IRC and by this chapter) or, as applicable, that the applicant's application has been rejected or excluded or has otherwise not been reserved credits in accordance

herewith. The written binding commitment shall prohibit any transfer, direct or indirect, of partnership interests (except those involving the admission of limited partners) prior to the placed-in-service date of the proposed development unless the transfer is consented to by the executive director. The written binding commitment shall further limit the developers' fees to the amounts established during the review of the applications for reservation of credits and such amounts shall not be increased unless consented to by the executive director.

If credits are reserved to any applicants for developments ~~which~~ that have also received an allocation of credits from prior years, the executive director may reserve additional credits from the current year equal to the amount of credits allocated to such developments from prior years, provided such previously allocated credits are returned to the authority. Any previously allocated credits returned to the authority under such circumstances shall be placed into the credit pools from which the current year's credits are reserved to such applicants.

The executive director shall make a written explanation available to the general public for any allocation of housing credit dollar amount ~~which~~ that is not made in accordance with established priorities and selection criteria of the authority.

The authority's board shall review and consider the analysis and recommendation of the executive director for the reservation of credits to an applicant, and, if it concurs with such recommendation, it shall by resolution ratify the reservation by the executive director of the credits to the applicant, subject to such terms and conditions as it shall deem necessary or appropriate to assure compliance with the aforementioned binding commitment issued or to be issued to the applicant, the IRC and this chapter. If the board determines not to ratify a reservation of credits or to establish any such terms and conditions, the executive director shall so notify the applicant.

~~Subsequent to such ratification of the reservation of credits, the executive director may, in his discretion and without ratification or approval by the board, increase the amount of such reservation by an amount not to exceed 10% of the initial reservation amount.~~

The executive director may require the applicant to make a good faith deposit or to execute such contractual agreements providing for monetary or other remedies as it may require, or both, to assure that the applicant will comply with all requirements under the IRC, this chapter and the binding commitment (including, without limitation, any requirement to conform to all of the representations, commitments and information contained in the application for which points were assigned pursuant to this section). Upon satisfaction of all such aforementioned requirements (including any post-allocation requirements), such deposit shall be refunded to the applicant or such contractual agreements shall terminate, or both, as applicable.

If, as of the date the application is approved by the executive director, the applicant is entitled to an allocation of the credits under the IRC, this chapter and the terms of any binding commitment that the authority would have otherwise issued to such applicant, the executive director may at that time allocate the credits to such qualified low-income buildings or development without first providing a reservation of such credits. This provision in no way limits the authority of the executive director to require a good faith deposit or contractual agreement, or both, as described in the preceding paragraph, nor to relieve the applicant from any other requirements hereunder for eligibility for an allocation of credits. Any such allocation shall be subject to ratification by the board in the same manner as provided above with respect to reservations.

The executive director may require that applicants to whom credits have been reserved shall submit from time to time or at such specified times as he shall require, written confirmation and documentation as to the status of the proposed development and its compliance with the application, the binding commitment and any contractual agreements between the applicant and the authority. If on the basis of such written confirmation and documentation as the executive director shall have received in response to such a request, or on the basis of such other available information, or both, the executive director determines any or all of the buildings in the development ~~which~~ that were to become qualified low-income buildings will not do so within the time period required by the IRC or will not otherwise qualify for such credits under the IRC, this chapter or the binding commitment, then the executive director may (i) terminate the reservation of such credits and draw on any good faith deposit, or (ii) substitute the reservation of credits from the current credit year with a reservation of credits from a future credit year~~,~~ if the delay is caused by a lawsuit beyond the applicant's control that prevents the applicant from proceeding with the development. If, in lieu of or in addition to the foregoing determination, the executive director determines that any contractual agreements between the applicant and the authority have been breached by the applicant, whether before or after allocation of the credits, he may seek to enforce any and all remedies to which the authority may then be entitled under such contractual agreements.

The executive director may establish such deadlines for determining the ability of the applicant to qualify for an allocation of credits as he shall deem necessary or desirable to allow the authority sufficient time, in the event of a reduction or termination of the applicant's reservation, to reserve such credits to other eligible applications and to allocate such credits pursuant thereto.

Any material changes to the development, as proposed in the application, occurring subsequent to the submission of the application for the credits therefor shall be subject to the prior written approval of the executive director. As a condition to

any such approval, the executive director may, as necessary to comply with this chapter, the IRC, the binding commitment and any other contractual agreement between the authority and the applicant, reduce the amount of credits applied for or reserved or impose additional terms and conditions with respect thereto. If such changes are made without the prior written approval of the executive director, he may terminate or reduce the reservation of such credits, impose additional terms and conditions with respect thereto, seek to enforce any contractual remedies to which the authority may then be entitled, draw on any good faith deposit, or any combination of the foregoing.

In the event that any reservation of credits is terminated or reduced by the executive director under this section, he may reserve, allocate or carry over, as applicable, such credits in such manner as he shall determine consistent with the requirements of the IRC and this chapter.

Notwithstanding the provisions of this section, the executive director may make a reservation of credits to any applicant that proposes a nonelderly development that (i) ~~provides rent subsidies or equivalent assistance~~ will be assisted by HUD project-based vouchers or another form of documented and binding federal [or state] project-based rent subsidies in order to ensure occupancy by extremely low-income persons; (ii) conforms to HUD regulations interpreting the accessibility requirements of § 504 of the Rehabilitation Act; and (iii) will be actively marketed to people with disabilities in accordance with a plan submitted as part of the application for credits and approved by the executive director for either [~~(i)~~ (a)] at least ~~50%~~ 25% of the units in the development or [~~(ii)~~ (b)] if HUD Section 811 funds are providing the rent subsidies, [~~as close to~~ at least 15%] but not more than [25% ~~10%~~] of the units in the development. Any such reservations made in any calendar year may be up to 6.0% of the Commonwealth's annual state housing credit ceiling for the applicable credit year. However, such reservation will be for credits from the Commonwealth's annual state housing credit ceiling from the following calendar year.

VA.R. Doc. No. R15-4144; Filed December 9, 2014, 2:32 p.m.

Final Regulation

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

Title of Regulation: **13VAC10-190. Mortgage Credit (adding 13VAC10-190-10 through 13VAC10-190-200).**

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

Effective Date: January 1, 2015.

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

Summary:

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

CHAPTER 190
RULES AND REGULATIONS FOR QUALIFIED MORTAGE CREDIT CERTIFICATE PROGRAMS

13VAC10-190-10. Definitions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. This chapter is intended to provide a general description of the authority's requirements and processing and is not intended to include all actions involved or required in the processing and administration of MCCs. This chapter is subject to amendment by the authority at any time and may be supplemented by policies, rules, and regulations adopted by the authority from time to time with respect to all of the programs.

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

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

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

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

13VAC10-190-40. Eligible persons.

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

13VAC10-190-50. Eligible properties.

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

13VAC10-190-60. Eligible lenders.

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

13VAC10-190-70. Eligible loans.

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

1. Is not funded in whole or in part from the proceeds of a qualified mortgage bond or a qualified veteran's mortgage bond as defined in IRC § 143,

2. Is incurred by the applicant to acquire his principal residence,

3. Is not being assumed from another borrower, and

4. Is not a refinancing of other indebtedness of the applicant, except in the case of construction period loans, bridge loans, or similar temporary financing that has a term of 24 months or less.

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

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

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

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

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

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

13VAC10-190-110. Certification of lenders.

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

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

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

13VAC10-190-120. Fees.

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

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

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

13VAC10-190-140. Priority of applications.

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

13VAC10-190-150. Targeted areas.

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

13VAC10-190-160. Discretion to allocate.

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

13VAC10-190-170. MCCs not transferable.

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

13VAC10-190-180. Applications for MCCs.

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

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

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

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

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

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

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

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

13VAC10-190-200. Compliance investigations.

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

VA.R. Doc. No. R15-4170; Filed December 4, 2014, 11:03 a.m.

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TITLE 14. INSURANCE

STATE CORPORATION COMMISSION

Final Regulation

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

Title of Regulation: **14VAC5-260. Rules Governing Insurance Holding Companies (amending 14VAC5-260-40, 14VAC5-260-50, 14VAC5-260-60, 14VAC5-260-80, 14VAC5-260-90, 14VAC5-260-110; adding 14VAC5-260-55, 14VAC5-260-85).**

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

Effective Date: January 1, 2015.

Agency Contact: Raquel C. Pino, Principal Insurance Analyst, Bureau of Insurance, State Corporation Commission, P.O. Box 1157, Richmond, VA 23218, telephone (804) 371-9499, FAX (804) 371-9511, or email raquel.pino@scc.virginia.gov.

Summary:

Chapter 309 of the 2014 Acts of Assembly incorporated revisions made to the National Association of Insurance Commissioners' Insurance Holding Company System Regulatory Act into the Code of Virginia. The proposed amendments address changes resulting from Chapter 309, including the State Corporation Commission's authority to (i) require the ultimate controlling person of an insurance holding company system to submit a confidential enterprise risk filing utilizing new Form F, (ii) require the parent company seeking to divest its interest in an insurance company subsidiary to provide notice to the domestic regulator prior to the divestiture, (iii) require the insurer's board of directors to make statements regarding the corporate governance and internal control responsibilities within the annual holding company registration statement, (iv) subject the cost-sharing services and management agreements among affiliated entities to minimum reporting requirements to eliminate the potential for capital to flow out of the insurer through these types of agreements, and (v) participate in supervisory colleges.

Changes made to 14VAC5-260-50 D 2 since publication of the proposed regulation clarify language regarding the commission's consideration of the potential negative impact on competition when reviewing an acquisition.

AT RICHMOND, DECEMBER 3, 2014

COMMONWEALTH OF VIRGINIA, ex rel.

STATE CORPORATION COMMISSION

CASE NO. INS-2014-00203

Ex Parte: In the matter of

Amending the Rules Governing

Insurance Holding Companies

ORDER ADOPTING RULES

By Order to Take Notice entered September 29, 2014,[1] ("Order") all interested parties were ordered to take notice that subsequent to November 20, 2014, the State Corporation Commission ("Commission") would consider the entry of an order to adopt amendments to the rules set forth in Chapter 260 of Title 14 of the Virginia Administrative Code, entitled Rules Governing Insurance Holding Companies, 14 VAC 5-260-10 et seq. ("Rules"), which amend the Rules at 14 VAC 5-260-40; 14 VAC 5-260-50; 14 VAC 5-260-60; 14 VAC 5-260-80; 14 VAC 5-260-90; and 14 VAC 5-260-110; adds new Rules at 14 VAC 5-260-55 and 14 VAC 5-260-85; revises current Forms A through F as proposed Forms A through E and G; and adds new Form F.

These amendments were proposed by the Bureau of Insurance ("Bureau") to implement the provisions of House Bill 109 passed by the 2014 General Assembly.[2] The

proposed amendments address, among other things, the Commission's authority to: 1) require the ultimate controlling person of an insurer to submit a confidential enterprise risk report; 2) require a parent company seeking to divest its interest in a domestic insurance company to provide notice to the Commission prior to the divestiture; 3) require an insurer's board of directors to make statements regarding corporate governance and internal control responsibilities within the annual holding company registration statement; 4) subject cost-sharing services and management agreements among affiliated entities to minimum reporting requirements; and 5) participate in supervisory colleges.

The Order required that on or before November 20, 2014, any person requesting a hearing on the amendments to the Rules shall have filed such request for a hearing with the Clerk of the Commission ("Clerk"). No request for a hearing was filed with the Clerk.

The Order also required all interested persons to file with the Clerk their comments in support of or in opposition to the amendments to the Rules on or before November 20, 2014. No comments were filed with the Clerk.

The Bureau recommends that the amendments to the Rules be adopted as proposed.

NOW THE COMMISSION, having considered this matter, is of the opinion that the Rules should be adopted as amended and revised.

Accordingly, IT IS ORDERED THAT:

(1) The proposed amendments to Rules Governing Insurance Holding Companies, which amend the Rules at 14 VAC 5-260-40; 14 VAC 5-260-50; 14 VAC 5-260-60; 14 VAC 5-260-80; 14 VAC 5-260-90; and 14 VAC 5-260-110; adds new Rules at 14 VAC 5-260-55 and 14 VAC 5-260-85; revises current Forms A through F as proposed Forms A through E and G; and adds new Form F, which are attached hereto and made a part hereof, are hereby ADOPTED to be effective January 1, 2015.

(2) AN ATTESTED COPY hereof, together with the attached adopted Rules, shall be sent by the Clerk of the Commission to the Bureau in care of Deputy Commissioner Douglas C. Stolte, who forthwith shall give further notice of the adopted rules by mailing a copy of this Order to every entity that is licensed, approved, registered, or accredited in Virginia under the provisions of Title 38.2 of the Code and also subject to solvency regulation in this Commonwealth pursuant to the provisions of Title 38.2 of the Code, as well as to all interested parties.

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

(4) This Order and the attached adopted Rules shall be posted on the Commission's website: http://www.scc.virginia.gov/case.

(5) The Bureau shall file with the Clerk of the Commission an affidavit of compliance with the notice requirements of Ordering Paragraph (2) above.

(6) This case is dismissed, and the papers filed herein shall be sent to the file for ended causes.

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[1] Doc. Con. Cen. No. 140950032.

[2] 2014 Va. Acts Ch. 309.

14VAC5-260-40. Acquisition of control; approval of applications.

A. A person filing an application or statement pursuant to § 38.2-1323 A, or any related provision of §§ 38.2-1324 through 38.2-1328, of the Act shall furnish the required information designated on Form A ~~of this chapter~~. A failure to file complete and accurate information as required by this chapter is grounds for a denial by the commission pursuant to § 38.2-1326.

~~1.~~ B. Where applicable and required by Form A, Form E shall also be filed.

~~2.~~ Whenever an application includes information in the format required by Form E, the commission may require an opinion of an economist as to the competitive impact of the proposed acquisition.

~~B.~~ C. When the person being acquired controls a domestic insurer, the person shall, for purposes of completing a Form A application, be deemed to be a "domestic insurer."

1. The name of the domestic subsidiary insurer should be indicated on the cover page as follows:

"ABC Insurance Company, a subsidiary of XYZ Holding Company"; and

2. References to "the insurer" contained in Form A shall refer to both the domestic subsidiary insurer and the person being acquired.

~~C.~~ D. The applicant shall promptly advise the commission of any material changes in the information so furnished on Form A, or any attachments thereto, arising subsequent to the date upon which the information was furnished, but prior to the commission's disposition of the application and consummation of the acquisition of control.

~~1.~~ Within two business days after the person filing the application learns of the change, an amendment setting forth the change, together with copies of all documents and other material relevant to the change, shall be filed with the commission. The filing shall be made with the clerk of the commission. Except where the applicant is also the insurer, the applicant shall show on each such filing that a copy has also been sent to the insurer.

~~2. A failure to file complete and accurate information as required by this chapter is grounds for a denial by the commission pursuant to § 38.2-1326.~~

~~3. As used in this section and for purposes of all Form A filings, "material change" includes any change in the identity of executive officers or any party to a merger or a liquidating transaction.~~

~~D.~~ E. Where "control" is derived from a management agreement, including any other agreement between a domestic insurer and another person other than a contract for goods or nonmanagement services, any termination of the agreement or any substitution of persons under the agreement shall be deemed a change of control requiring notice and application to the commission pursuant to § 38.2-1323 of the Act.

~~E.~~ F. A person seeking to merge with or acquire a domestic insurer may apply to the commission for an order exempting the person from the provisions of §§ 38.2-1323 through 38.2-1327 if the merger or acquisition meets the standards for exemption provided in § 38.2-1328.

1. The application shall be in writing and shall be filed with the clerk of the commission. Filing instructions are the same as for a Form A filing. See Section III of the Form A Instructions for information regarding number of copies, signature requirements, and electronic filing. The applicant shall identify the parties to the merger or acquisition and shall state (i) the purpose of the merger or acquisition, (ii) the method of merger or acquisition, and (iii) why the person believes the exemption criteria of § 38.2-1328 will be met.

2. Within 30 days after the application for exemption is filed with the clerk of the commission, the commission shall enter an order granting the exemption or giving notice of a hearing to determine the merits of the application.

~~F.~~ G. Any hearing held to consider an application filed pursuant to the provisions of this section and § 38.2-1323 of the Act shall be held pursuant to § 38.2-1326 and shall begin, unless waived by the insurer, within 40 days of the date the application is filed with the commission. An application shall be deemed filed upon receipt by the commission of all material required by this section or § 38.2-1324 of the Act.

14VAC5-260-50. Acquisitions involving insurers not otherwise covered.

A. An acquisition covered by § 38.2-1323 B of the Act may be subject to orders pursuant to § 38.2-1323 B and C of the ~~Code of Virginia~~ Act unless the acquiring party files a pre-acquisition notification or an acquisition statement in the format prescribed by Form E ~~of this chapter~~. The person being acquired may file the statement. If a nondomiciliary insurer licensed to do business in this Commonwealth is proposing a merger or acquisition pursuant to § 38.2-1323 A of the Act, that person shall file a pre-acquisition notification form, Form E. No pre-acquisition notification form need be filed if the acquisition is beyond the scope of § 38.2-1323 A as set forth in subdivision B 2 of this section.

In addition to the information required by Form E, the commission may wish to require an expert opinion as to the competitive impact of the proposed acquisition.

~~1. The commission may enter an order suspending~~ B. 1. Except as exempted in subdivision 2 of this subsection, this section applies to any acquisition in which there is a change in control of an insurer authorized to do business in this Commonwealth.

2. This section shall not apply to the following:

a. A purchase of securities solely for investment purposes so long as the securities are not used to cause or attempt to cause the substantial lessening of competition in any insurance market in this Commonwealth. If a purchase of securities results in a presumption of control, as defined in § 38.2-1322 of the Act, it is not solely for investment purposes unless the commissioner of the insurer's state of domicile accepts a disclaimer of control or affirmatively finds that control does not exist and the disclaimer action or affirmative finding is communicated by the domiciliary insurance commissioner, director, or superintendent to the commission;

b. The acquisition of a person by another person when both persons are neither directly nor through affiliates primarily engaged in the business of insurance, if pre-acquisition notification is filed with the commission in accordance with subdivision C 1 of this section 30 days prior to the proposed effective date of the acquisition. However, such pre-acquisition notification is not required for exclusion from this section if the acquisition would otherwise be excluded from this section by any other provision in this subdivision B 2;

c. The acquisition of already affiliated persons; or

d. An acquisition if, as an immediate result of the acquisition:

(1) In no market would the combined market share of the involved insurers exceed 5.0% of the total market;

(2) There would be no increase in any market share; or

(3) In no market would the combined market share of the involved insurers exceed 12% of the total market, and the market share increase by more than 2.0% of the total market.

For the purpose of this subdivision, a market means direct written insurance premium in this Commonwealth for a line of business as contained in the annual statement required to be filed by insurers licensed to do business in this Commonwealth.

C. An acquisition covered by subsection B of this section may be subject to an order pursuant to subsection E of this section unless the acquiring person files a pre-acquisition notification and the waiting period has expired. The acquired

person may file a pre-acquisition notification. The commission shall give confidential treatment to information submitted under this subsection in the same manner as provided in § 38.2-1333 of the Act.

1. The pre-acquisition notification shall be in such form and contain such information as prescribed by the NAIC relating to those markets that, under subdivision B 2 d of this section, cause the acquisition not to be exempted from the provisions of this section. The commission may require such additional material and information as deemed necessary to determine whether the proposed acquisition, if consummated, would violate the competitive standard of subsection D of this section. The required information may include an opinion of an economist as to the competitive impact of the acquisition in this Commonwealth accompanied by a summary of the education and experience of the economist indicating his ability to render an informed opinion.

2. The waiting period required shall begin on the date of receipt by the commission of a pre-acquisition notification and shall end on the earlier of the 30th day after the date of receipt or termination of the waiting period by the commission. Prior to the end of the waiting period, the commission may require the submission of additional needed information relevant to the proposed acquisition, in which event the waiting period shall end on the earlier of the 30th day after receipt of the additional information by the commission or termination of the waiting period by the commission.

D. 1. The commission may enter an order under subdivision E 1 of this section with respect to an acquisition if there is substantial evidence that the effect of the acquisition may be substantially to lessen competition in any line of insurance in this Commonwealth or tend to create a monopoly or if the insurer fails to file adequate information in compliance with subsection C of this section.

2. In determining whether competition may be [~~detrimental~~ negatively impacted], the commission [~~shall~~ may] consider, among other things, whether applicable competitive standards promulgated by the NAIC have or may be violated as a consequence of the acquisition. The standards may include any indicators of competition identified or enumerated by the NAIC in any model laws or portions of practice and procedure or instructional manuals developed to provide guidance in regulatory oversight of holding company systems, mergers and acquisitions, or competitive practices within the marketplace. The standards include the definitions, guidelines, or standards embodied in any model holding company act or model holding company regulation adopted by the NAIC. In addition, the commission may request and consider the opinion of an economist as to the competitive impact of the acquisition whenever pre-acquisition notification is submitted pursuant to § 38.2-1323 B of the Act.

E. 1. a. If an acquisition violates the standards of this section, the commission may enter an order:

(1) Requiring an involved insurer to cease and desist from doing business in this Commonwealth with respect to the line or lines of insurance involved in the violation.

(2) Denying the application of an acquired or acquiring insurer for a license to do business in this Commonwealth.

(3) Suspending the license of an insurer involved in an acquisition if there is substantial evidence that the effect of the acquisition may be substantially to lessen competition in any line of insurance in this Commonwealth or tend to create a monopoly therein, and is detrimental to policyholders or the public in general.

~~2. An order suspending~~ (4) Suspending the license ~~may also be entered~~ if the insurer fails to file adequate information sufficient to rebut a reasonable belief that the merger or acquisition causes or tends to cause a substantial lessening of competition in any line of insurance, and also is detrimental to policyholders or the public.

~~3. In determining whether competition may be detrimental, the commission shall consider, among other things, whether applicable competitive standards promulgated by the NAIC have or may be violated as a consequence of the acquisition. The standards may include any indicators of competition identified or enumerated by the NAIC in any model laws or portions of practice and procedure or instructional manuals developed to provide guidance in regulatory oversight of holding company systems, mergers and acquisitions, or competitive practices within the marketplace. The standards include the definitions, guidelines or standards embodied in any model holding company act or model holding company regulation adopted by the NAIC. In addition, the commission may request and consider the opinion of an economist as to the competitive impact of the acquisition whenever pre-acquisition notification is submitted pursuant to § 38.2-1323 B of the Act.~~

~~4.~~ b. An order suspending the license shall not be entered under § 38.2-1323 B of the Act unless the involved insurer has received 10 days' notice and an opportunity to be heard. The notice of hearing shall be accompanied by a request for information as required by § 38.2-1324 of the Act; it may include also a request for an opinion of an economist as to the competitive impact of the acquisition.

~~a.~~ (1) Requested information shall be filed as an acquisition statement in the format of Form E ~~of this chapter~~.

~~b.~~ (2) If the commission determines that the acquisition or merger causes or tends to cause a substantial lessening

of competition in any line of insurance, the commission may request the insurer to furnish the additional information required by § 38.2-1324, in order to rebut the reasonable belief that the lessening of competition is detrimental to policyholders or the public in general.

~~5.~~ c. An order suspending the license shall not be entered under § 38.2-1323 B of the ~~Code of Virginia~~ Act and this section if:

~~a.~~ (1) The acquisition will yield substantial economies of scale or economies in resource utilization that cannot be feasibly achieved in any other way, and the public benefits which would arise from the economies exceed the public benefits which would arise from not lessening competition; or

~~b.~~ (2) The acquisition will substantially increase the availability of insurance, and the public benefits of the increase exceed the public benefits which would arise from not lessening competition.

~~6.~~ d. The commission's order suspending the license entered under this section shall not become final earlier than 21 days after it is issued, during which time the involved insurer may submit a plan to remedy the anticompetitive impact of the acquisition within a reasonable time. Based upon the plan or other information, the commission shall specify the conditions, if any, under the time period during which the aspects of the acquisition causing a violation of the applicable competitive standards announced by the commission would be remedied and the order vacated or modified.

e. An order pursuant to this subsection shall not apply if the acquisition is not consummated.

2. Any person who violates a cease and desist order of the commission under subdivision 1 of this subsection and while the order is in effect may, after notice and hearing and upon order of the commission, be subject at the discretion of the commission to one or more of the following:

a. A monetary penalty pursuant to § 38.2-218 of the Code of Virginia; or

b. Suspension or revocation of the person's license.

3. Any insurer or other person who fails to make any filing required by this section, and who also fails to demonstrate a good faith effort to comply with any filing requirement, shall be subject to a monetary penalty pursuant to § 38.2-218.

~~B.~~ F. Any hearing held pursuant to the provisions of this section shall begin, unless waived by the insurer, within 40 days of the date of receipt by the commission of all material required by § 38.2-1323 of the Act.

~~C.~~ G. For the purposes of this section and § 38.2-1323 B of the Act, "acquisition" means any agreement, arrangement, or activity the consummation of which results in a person acquiring directly or indirectly control of another person, and includes but is not limited to the acquisition of voting securities, the acquisition of assets, bulk reinsurance, and mergers. "Involved insurer" includes an insurer that either acquires or is acquired, is affiliated with an acquirer or acquired, or is the result of a merger.

H. Section 38.2-1334.1 A and C and Chapter 15 (§ 38.2-1500 et seq.) of Title 38.2 of the Code of Virginia do not apply to acquisitions covered under subsection B of this section.

14VAC5-260-55. Subsidiaries of insurers.

Investments in insurance subsidiaries are exempt from § 38.2-1330 B 6 of the Act to the extent they do not exceed the lesser of 10% of the insurer's assets or 50% of the insurer's surplus as regards policyholders. The authority to invest in subsidiaries under this section is in addition to any authority to invest in subsidiaries that may be contained in any other provision of Title 38.2 of the Code of Virginia.

14VAC5-260-60. Annual registration of insurers; registration statement filings and amendments.

A. An insurer required to file a registration statement pursuant to § 38.2-1329 of the Act shall furnish the required information in the format designated on Form B.

1. The initial registration statement shall be filed with the commission within 15 days after the insurer becomes subject to registration under § 38.2-1329 of the Act.

2. Annually thereafter by April 30 of each year, for the previous calendar year, the registrant shall file a completely restated up-to-date registration statement in the format designated on Form B, with amendments consolidated therein. Each registration statement shall contain a summary outlining all items in the current registration statement representing changes from the prior registration statement. The summary shall be prepared in the format designated on Form C, as specified in the instructions of that form, which is a part of this chapter.

~~B. An insurer shall file a copy of its most current registration statement and the Form C filing, also known as a Summary of Registration Filing, in each state in which the insurer is authorized to do business, if requested by the insurance commissioner of that state.~~

~~C.~~ B. Amendments to Form B.

1. An amendment to Form B shall be filed under the following conditions:

a. Within 15 days after the end of any month in which there is a material change to the information provided in the annual registration statement;

b. Within 15 days after the end of any month in which the registrant or insurer learns there is a change in control of the registrant, in which case all of Form B and Form C shall be made current;

c. Within 15 days after the end of any month in which the registrant or insurer learns there is a material change in information given in Item 5 of Form B;

d. Within 30 days after the investment in any one corporation, if the total investment in that corporation, by the insurance holding company system, exceeds 10% of that corporation's voting securities;

e. Within 15 days after the end of any month in which there is a material change in any portion of the information given in Item 6 of Form B;

f. Within 15 days after the end of any month in which there is a change of the chief executive officer, president, or more than 1/3 of the directors reported in Item 4 of Form B;

g. Within five business days following the declaration of any dividend or other distribution to an insurer's shareholder or shareholders; and

h. Within 120 days after the end of each fiscal year of the ultimate controlling person of the insurance holding company system.

2. Amendments shall be filed in the Form B format. Subject to the provisions of subdivision A 2 of this section, only those items which are being amended need be reported. Each amendment shall include at the top of the cover page "Amendment No. (insert number) to Registrant Statement, brought current from (insert year)" and shall indicate as its "Date," the date of the change and not the date of the original filings. Filings made in the format of Forms A, D, E, or ~~F~~ G may be deemed amendments filed in the Form B format when accompanied by certification under oath or affirmation that the transaction reported on Form A, D, E, or ~~F~~ G has been consummated. If the commission's approval of the transaction is required by the Act, the certification shall state also that consummation was pursuant to terms and agreements approved by the commission.

3. As used in this section, "material transaction" has the meaning set forth in § 38.2-1322 of the Act except that, unless the commission by rule, order, or regulation prescribes otherwise, no sale, purchase, exchange, loan, or extension of credit or investment shall be considered "material" unless it involves at least 0.5% of an insurer's admitted assets or 5.0% of the insurer's surplus to policyholders, as of the immediately preceding December 31. Any sale or other transaction which is one of a series of transactions occurring within a 12-month period that are sufficiently similar in nature as to be reasonably construed as a single transaction and that in the aggregate exceed the minimum limits herein provided shall be deemed a material transaction.

~~D.~~ C. Exemptions and alternative and consolidated registrations.

1. Any insurer which is authorized to do business in this Commonwealth may file a registration statement on behalf of any affiliated insurer or insurers which are required to register under § 38.2-1329 of the Act. A registration statement may include information not required by the Act regarding any insurer in the insurance holding company system even if the insurer is not authorized to do business in this Commonwealth. In lieu of filing a registration statement on Form B, the authorized insurer may file a copy of the registration statement or similar report which it is required to file in its state of domicile, provided:

a. The statement or report contains substantially similar information required to be furnished on Form B; and

b. The filing insurer is the principal insurance company in the insurance holding company system.

2. The question of whether the filing insurer is the principal insurance company in the insurance holding company system is a question of fact and an insurer filing a registration statement or report in lieu of Form B on behalf of an affiliated insurer, shall set forth a brief statement of facts which will substantiate the filing insurer's claim that it, in fact, is the principal insurer in the insurance holding company system.

3. With the prior approval of the commission, an insurer not licensed to transact the business of insurance in this Commonwealth may follow any of the procedures which could be done by an authorized insurer under subdivision 1 of this subsection.

4. Any insurer may take advantage of the provisions of § 38.2-1329 ~~G~~ H or ~~§ 38.2-1329 H~~ I of the Act without obtaining the prior approval of the commission. The commission, however, reserves the right to require individual filings if it deems the filings necessary in the interest of clarity, ease of administration, or the public good.

5. The state of entry of an alien insurer shall be deemed to be its state of domicile for the purpose of this chapter.

6. Any foreign insurer subject to disclosure requirements and standards adopted by statute or regulation in the jurisdiction of its domicile that are substantially similar to those contained in § 38.2-1329 of the Act, shall be exempted and excepted from registration in this Commonwealth pursuant to this section and § 38.2-1329 A of the Act; however, if requested by the commission, the insurer shall furnish to the commission a copy of the registration statement or other information filed with its state of domicile. The information shall be filed with the commission within 15 days after the commission makes its request.

7. Any insurer not otherwise exempt or excepted from § 38.2-1329 of the ~~Code of Virginia~~ Act may apply for an exemption from the requirements of § 38.2-1329 of the

~~Code of Virginia~~ Act by submitting a statement to the commission setting forth its reasons for being exempt.

14VAC5-260-80. Transactions subject to prior notice filing.

A. An insurer required to give notice of a proposed transaction pursuant to § ~~38.2-1331~~ 38.2-1330 B of the Act shall furnish the required information in the format designated on Form D, as specified in the instructions of that form, which is a part of this chapter.

B. Agreements for cost-sharing services and management services shall at a minimum and as applicable:

1. Identify the person providing services and the nature of such services;

2. Set forth the methods to allocate costs;

3. Require timely settlement, not less frequently than on a quarterly basis, and compliance with the requirements in the National Association of Insurance Commissioners Accounting Practices and Procedures Manual, As of March 2014;

4. Prohibit advancement of funds by the insurer to the affiliate except to pay for services defined in the agreement;

5. State that the insurer will maintain oversight for functions provided to the insurer by the affiliate and that the insurer will monitor services annually for quality assurance;

6. Define books and records of the insurer to include all books and records developed or maintained under or related to the agreement;

7. Specify that all books and records of the insurer are and remain the property of the insurer and are subject to control of the insurer;

8. State that all funds and invested assets of the insurer are the exclusive property of the insurer, held for the benefit of the insurer, and subject to the control of the insurer;

9. Include standards for termination of the agreement with and without cause;

10. Include provisions for indemnification of the insurer in the event of gross negligence or willful misconduct on the part of the affiliate providing the services;

11. Specify that, if the insurer is placed in receivership or seized by the commission under the Rehabilitation and Liquidation of Insurers statute (Chapter 15 (§ 38.2-1500 et seq.) of Title 38.2 of the Code of Virginia):

a. All of the rights of the insurer under the agreement extend to the receiver or commission; and

b. All books and records will immediately be made available to the receiver or the commission, and shall be turned over to the receiver or commission immediately upon the receiver or the commission's request;

12. Specify that the affiliate has no automatic right to terminate the agreement if the insurer is placed in receivership pursuant to Chapter 15 of Title 38.2 of the Code of Virginia; and

13. Specify that the affiliate will continue to maintain any systems, programs, or other infrastructure notwithstanding a seizure by the commission under Chapter 15 of Title 38.2 of the Code of Virginia, and will make them available to the receiver for so long as the affiliate continues to receive timely payment for services rendered.

C. The approval of any material transactions pursuant to § ~~38.2-1331~~ 38.2-1330 B of the Act shall be deemed an amendment to an insurer's registration statement under § 38.2-1329 C ~~4~~ 6 of the Act without further filing other than written confirmation under oath or affirmation by registrant that the transaction as approved by the commission has been consummated. The confirmation shall be filed within two business days following consummation of the approved transaction.

14VAC5-260-85. Enterprise risk report.

The ultimate controlling person of an insurer required to file an enterprise risk report pursuant to § 38.2-1329 L of the Act shall furnish the required information on Form F.

14VAC5-260-90. Dividends and other distributions.

A. Each registered insurer shall report to the commission as required under § ~~38.2-1329~~ 38.2-1330.1 of the Act, all dividends and other distributions to shareholders within five business days following declaration. An insurer shall not pay a dividend or other distribution until 30 days after the commission has received written notice of the declaration thereof and has not within such period disapproved such payment. The commission may approve the payment of such dividend or other distribution prior to the 30 days. Such dividends and other distributions are to be paid out of earned surplus unless the commission has provided prior written approval for such dividends or other distributions to be paid from another source. Except as provided in subsection B of this section, the report shall be filed in the format prescribed by Form ~~F~~ G and shall include at least the following:

1. A statement stating whether the dividend or distribution is extraordinary. If the dividend or distribution is extraordinary, the insurer also shall state the date of approval, if any, obtained pursuant to § 38.2-1330.1 A of the Act, or the earliest date on which approval may be deemed;

2. Earned surplus as of the immediately preceding December 31;

3. The amount of the proposed dividend;

4. The date of declaration, date of record, and date established for payment of the dividend;

5. A statement as to whether the dividend is to be in cash or other property and, if in property, a description thereof,

its cost, and its fair market value together with an explanation of the basis for valuation;

6. The amounts, dates, and form of payment of all dividends or distributions (including regular dividends but excluding distributions of the insurer's own securities) paid within the period of 12 consecutive months ending on the date fixed for payment of the proposed dividend for which approval is sought and commencing on the day after the same day of the same month in the last preceding year;

7. A brief statement as to the effect of the proposed dividend upon the insurer's surplus and the reasonableness of surplus in relation to the insurer's outstanding liabilities and the adequacy of surplus relative to the insurer's financial needs; and

8. A statement identifying any and all revaluations of assets.

B. If payment of an extraordinary dividend or distribution has been approved prior to its declaration, the insurer may comply with the requirements of § 38.2-1329 ~~E~~ F of the Act by filing written confirmation under oath or affirmation that the extraordinary dividend or distribution, as approved by the commission, has been declared. Confirmation shall be filed within five business days following declaration.

C. An insurer may obtain prior approval of an extraordinary dividend or distribution, as required by § 38.2-1330.1 A of the Act, by filing a request for approval with the commission. The request for approval shall be filed in the format prescribed by Form ~~F~~ G and shall include at least the following:

1. All the information required in subsection A of this section;

2. Statements of financial condition and earnings for the period intervening from the last annual statement filed with the commission and the end of the month preceding the month in which the request for dividend approval is submitted; and, if the date of payment or distribution is more than 60 days removed from the date of the most current financial statement submitted by the insurer, the insurer shall include also a pro forma statement as of the day after the distribution or payment of the dividend showing its effect and other known and reasonably projected adjustments to the financial condition and earnings of the insurer; and

3. A copy of the calculations determining that the proposed dividend is extraordinary. The work paper shall include the following information:

a. The amounts, dates, and form of payment of all dividends or distributions (including regular dividends but excluding distributions of the insurer's own securities) paid within the period of 12 consecutive months ending on the date fixed for payment of the proposed dividend for which approval is sought, and commencing on the day after the same day of the same month in the last preceding year;

b. Surplus as regards to policyholders (total capital and surplus) as of the immediately preceding December 31;

c. If the insurer is a life insurer, the net gain from operations for the 12-month period ending the immediately preceding December 31; ~~and~~

d. If the insurer is not a life insurer, the net income less realized capital gains for the 12-month period ending the ~~immediately preceding December 31, but shall not include pro rata distributions of any class of the insurer's own securities.~~ 31st day of December next preceding and the two preceding 12-month periods; and

e. If the insurer is not a life insurer, the dividends paid to shareholders excluding distributions of the insurer's own securities in the preceding two calendar years.

4. Statements on each factor set forth in § 38.2-1330 ~~B~~ D of the Act must be submitted in support of the request for approval of an extraordinary dividend or distribution, although these factors are not intended to be an exhaustive list. In determining the adequacy and reasonableness of an insurer's surplus no single factor is controlling. The commission, instead, will consider the net effect of all of these factors plus other factors bearing on the financial condition of the insurer. In comparing the surplus maintained by other insurers, the commission will consider the extent to which each of these factors varies from company to company and in determining the quality and liquidity of investments in subsidiaries, the commission will consider the individual subsidiary and may discount or disallow its valuation to the extent that the individual investments so warrant.

5. In addition, in order to determine the possibility of any financial effect on the insurer, the commission may request the means of funding and the purpose of the extraordinary dividend or distribution.

D. No declaration of an extraordinary dividend or distribution shall confer any rights on shareholders without the prior approval thereof pursuant to § 38.2-1330.1 ~~C~~ D of the Act. However, an insurer may declare an extraordinary dividend or distribution which is conditioned upon the commission's approval, and the declaration shall confer no rights upon shareholders until (i) the commission has approved the payment of the dividend or distribution or (ii) the commission has not disapproved the payment within the 30-day period provided by § 38.2-1330.1 A of the Act.

14VAC5-260-110. Severability clause.

If any provision ~~of~~ in this chapter or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the chapter and the application of the provision to other persons or circumstances shall not be affected thereby.

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

FORMS (14VAC5-260)

~~Form A, Instructions for Application for Approval of Acquisition of Control of or Merger with a Domestic Insurer Pursuant to § 38.2-1323 of the Code of Virginia (rev. 9/09)~~

~~Form B, Instructions for Insurance Holding Company System Annual Registration Statement Pursuant to § 38.2-1329 of the Code of Virginia (rev. 9/09)~~

~~Form C, Instructions for Summary of Registration Statement Pursuant to § 38.2-1329 of the Code of Virginia (rev. 7/06)~~

~~Form D, Instructions for Prior Notice and Application for Approval of Certain Transactions Pursuant to § 38.2-1331 of the Code of Virginia (rev. 7/06)~~

~~Form E, Instructions for an Acquisition Statement Reporting Competitive Impact Data Pursuant to § 38.2-1323 of the Code of Virginia (rev. 7/06)~~

~~Form F, Instructions for Notice of Dividends and Distributions to Shareholders Pursuant to §§ 38.2-1329 E and 38.2-1330.1 of the Code of Virginia (rev. 9/09)~~

Form A, Instructions for Application for Approval of Acquisition of Control of or Merger with a Domestic Insurer Pursuant to § 38.2-1323 of the Code of Virginia, and Application (rev. 1/15)

Form B, Instructions for Insurance Holding Company System Annual Registration Statement Pursuant to § 38.2-1329 of the Code of Virginia, and Statement (rev. 1/15)

Form C, Instructions for Summary of Changes to Registration Statement Pursuant to § 38.2-1329 of the Code of Virginia, and Summary (rev. 1/15)

Form D, Instructions for Prior Notice and Application for Approval of Certain Transactions Pursuant to § 38.2-1330 B of the Code of Virginia, and Notice and Application (rev. 1/15)

Form E, Instructions for Pre-Acquisition Notification Form Regarding the Potential Competitive Impact of a Proposed Merger or Acquisition by a Non-Domiciliary Insurer Doing Business in this Commonwealth or by a Domestic Insurer Pursuant to § 38.2-1323 of the Code of Virginia, and Notification (rev. 1/15)

Form F, Instructions for Enterprise Risk Report Pursuant to § 38.2-1329 L of the Code of Virginia, and Report (eff. 1/15)

Form G, Instructions for Notice of Dividends and Distributions to Shareholders Pursuant to §§ 38.2-1329 F and 38.2-1330.1 of the Code of Virginia, and Notice (rev. 1/15)

DOCUMENTS INCORPORATED BY REFERENCE (14VAC5-260)

Accounting Practices & Procedures Manual, As of March 2014, National Association of Insurance Commissioners, 1100 Walnut Street, Suite 1500, Kansas City, MO 64106, www.naic.org

VA.R. Doc. No. R15-4045; Filed December 3, 2014, 12:15 p.m.

Final Regulation

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

Titles of Regulations: **14VAC5-70. Rules Governing Accelerated Benefits Provisions (amending 14VAC5-70-130).**

14VAC5-200. Rules Governing Long-Term Care Insurance (amending 14VAC5-200-140, 14VAC5-200-153).

14VAC5-310. Rules Governing Actuarial Opinions and Memoranda (amending 14VAC5-310-10 through 14VAC5-310-50, 14VAC5-310-90).

14VAC5-319. Life Insurance Reserves (amending 14VAC5-319-10).

14VAC5-321. Use of the 2001 CSO Mortality Table in Determining Reserve Liabilities and Nonforfeiture Benefits (amending 14VAC5-321-10, 14VAC5-321-30, 14VAC5-321-40).

14VAC5-322. Use of the 2001 CSO Preferred Class Structure Mortality Table in Determining Reserve Liabilities (amending 14VAC5-322-10).

14VAC5-323. Rules Governing Preneed Life Insurance Minimum Standards for Determining Reserve Liabilities and Nonforfeiture Values (amending 14VAC5-323-10, 14VAC5-323-40, 14VAC5-323-50).

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

Effective Date: January 1, 2015.

Agency Contact: Raquel C. Pino, Principal Insurance Analyst, Bureau of Insurance, State Corporation Commission, P.O. Box 1157, Richmond, VA 23218, telephone (804) 371-9499, FAX (804) 371-9511, or email raquel.pino@scc.virginia.gov.

Summary:

The amendments update the Code of Virginia citations that will be effective January 1, 2015, to reflect changes enacted by Chapter 571 of the 2014 Acts of Assembly. Chapter 571 is based on revisions to the National Association of Insurance Commissioners' (NAIC) Standard

Valuation Law model, which was adopted by the NAIC in 2009. The revised model authorizes a principle-based reserve (PBR) basis for life, annuity, and accident and health contracts, and requires the use of a Valuation Manual, which contains both PBR and non-PBR requirements, as well as actuarial opinion and corporate governance requirements.

AT RICHMOND, DECEMBER 3, 2014

COMMONWEALTH OF VIRGINIA, ex rel.

STATE CORPORATION COMMISSION

CASE NO. INS-2014-00202

Ex Parte: In the matter of Amending the
Rules Governing Accelerated Benefits Provisions;
the Rules Governing Long-Term Care Insurance;
the Rules Governing Actuarial Opinions and Memoranda;
Life Insurance Reserves; Use of the 2001 CSO
Mortality Table in Determining Reserve Liabilities
and Nonforfeiture Benefits; Use of the 2001 CSO
Preferred Class Structure Mortality Table in
Determining Reserve Liabilities; and
Preneed Life Insurance Minimum Standards for Determining
Reserve Liabilities and Nonforfeiture Values

ORDER ADOPTING RULES

By Order to Take Notice ("Order") entered September 16, 2014[1], all interested parties were ordered to take notice that subsequent to October 31, 2014, the State Corporation Commission ("Commission") would consider the entry of an order to adopt amendments to the rules set forth in Chapters 70, 200, 310, 319, 321, 322, and 323 of Title 14 of the Virginia Administrative Code, entitled Rules Governing Accelerated Benefits Provisions, 14 VAC 5-70-10 et seq.; Rules Governing Long-Term Care Insurance, 14 VAC 5-200-10 et seq.; Rules Governing Actuarial Opinions and Memoranda, 14 VAC 5-310-10 et seq.; Life Insurance Reserves, 14 VAC 5-319-10 et seq.; Use of the 2001 CSO Mortality Table in Determining Reserve Liabilities and Nonforfeiture Benefits, 14 VAC 5-321-10 et seq.; Use of the 2001 CSO Preferred Class Structure Mortality Table in Determining Reserve Liabilities, 14 VAC 5-322-10 et seq.; and Preneed Life Insurance Minimum Standards for Determining Reserve Liabilities and Nonforfeiture Values, 14 VAC 5-323-10 et seq. (collectively, "Rules"), respectively, which amend the Rules at 14 VAC 5-70-130; 14 VAC 5-200-140; 14 VAC 5-200-153; 14 VAC 5-310-10 through 14 VAC 5-310-50; 14 VAC 5-310-90; 14 VAC 5-319-10; 14 VAC 5-321-10; 14 VAC 5-321-30; 14 VAC 5-321-40; 14 VAC 5-322-10; 14 VAC 5-323-10; 14 VAC 5-323-40; and 14 VAC 5-323-50.

These amendments were proposed by the Bureau of Insurance ("Bureau") to implement the provisions of House Bill 631 passed by the 2014 General Assembly, which amends the Code of Virginia ("Code") by adding in Chapter 13 of Title 38.2 of the Code an Article numbered 10, consisting of sections numbered 38.2-1365 through 38.2-1385 of the Code. The new sections of the Code authorize a principle-based reserve ("PBR") basis for life, annuity, and accident and health contracts, and require the use of a Valuation Manual that contains both PBR and non-PBR requirements, as well as actuarial opinion and corporate governance requirements. The amendments to the Rules replace the current citations to Title 38.2 of the Code with citations that will be effective on January 1, 2015.

The Order required that on or before October 31, 2014, any person requesting a hearing on the amendments to the Rules shall have filed such request for a hearing with the Clerk of the Commission ("Clerk"). No request for a hearing was filed with the Clerk.

The Order also required all interested persons to file with the Clerk their comments in support of or in opposition to the amendments to the Rules on or before October 31, 2014. No comments were filed with the Clerk.

The Bureau recommends that the amendments to the Rules be adopted as proposed.

NOW THE COMMISSION, having considered this matter, is of the opinion that the Rules should be adopted as amended and revised.

Accordingly, IT IS ORDERED THAT:

(1) The proposed amendments to Rules Governing Accelerated Benefits Provisions; Rules Governing Long-Term Care Insurance; Rules Governing Actuarial Opinions and Memoranda; Life Insurance Reserves; Use of the 2001 CSO Mortality Table in Determining Reserve Liabilities and Nonforfeiture Benefits; Use of the 2001 CSO Preferred Class Structure Mortality Table in Determining Reserve Liabilities; and Preneed Life Insurance Minimum Standards for Determining Reserve Liabilities and Nonforfeiture Values, which amend the Rules at 14 VAC 5-70-130; 14 VAC 5-200-140; 14 VAC 5-200-153; 14 VAC 5-310-10 through 14 VAC 5-310-50; 14 VAC 5-310-90; 14 VAC 5-319-10; 14 VAC 5-321-10; 14 VAC 5-321-30; 14 VAC 5-321-40; 14 VAC 5-322-10; 14 VAC 5-323-10; 14 VAC 5-323-40; and 14 VAC 5-323-50, which are attached hereto and made a part hereof, are hereby ADOPTED to be effective January 1, 2015.

(2) AN ATTESTED COPY hereof, together with a copy of the adopted Rules, shall be sent by the Clerk to the Bureau in care of Deputy Commissioner Douglas C. Stolte, who forthwith shall give further notice of the adopted Rules by mailing a copy of this Order, together with the adopted Rules, to every entity that is licensed, approved, registered, or accredited in Virginia under the provisions of Title 38.2 of the Code and also subject to solvency regulation in this Commonwealth pursuant to the provisions of Title 38.2 of the Code, as well as to all interested parties.

(3) The Commission's Division of Information Resources forthwith shall cause a copy of this Order, together with

the adopted Rules, to be forwarded to the Virginia Registrar of Regulations for appropriate publication in the Virginia Register of Regulations.

(4) This Order and the attached adopted Rules shall be posted on the Commission's website: http://www.scc.virginia.gov/case.

(5) The Bureau shall file with the Clerk an affidavit of compliance with the notice requirements of Ordering Paragraph (2) above.

(6) This case is dismissed, and the papers filed herein shall be placed in the file for ended causes.

[1] Doc. Con. Cen. No. 140920130.

14VAC5-70-130. Actuarial disclosure and reserves.

A. A qualified actuary shall be required to describe the accelerated benefits, the risks, the expected costs and the calculation of statutory reserves in an actuarial memorandum accompanying each filing. The insurer shall maintain in its files descriptions of the bases and procedures used to calculate benefits payable under these provisions. These descriptions shall be made available for examination by the commission upon request.

B. 1. When benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves shall be determined in accordance with §§ ~~38.2-3126~~ 38.2-1365 through ~~38.2-3144~~ 38.2-1385 of the Code of Virginia. All valuation assumptions used in constructing the reserves shall be determined as appropriate for statutory valuation purposes by a member in good standing of the American Academy of Actuaries. Mortality tables and interest currently recognized for life insurance reserves by the National Association of Insurance Commissioners may be used as well as appropriate assumptions for the other provisions incorporated in the policy form. The actuary must follow both actuarial standards and certification for good and sufficient reserves. Reserves in the aggregate should be sufficient to cover:

a. Policies upon which no claim has yet arisen.

b. Policies upon which an accelerated claim has arisen.

2. For policies and certificates which provide actuarially equivalent benefits, no additional reserves need to be established.

3. Policy liens and policy loans, including accrued interest, represent assets of the company for statutory reporting purposes. For any policy on which the policy lien exceeds the policy's statutory reserve liability such excess must be held as a nonadmitted asset.

14VAC5-200-140. Reserve standards.

A. When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves for such benefits shall be determined in accordance with subdivision 7 of § ~~38.2-3130~~ 38.2-1369 of the Code of Virginia. Claim reserves must also be established in the case when such policy or rider is in claim status. Reserves for policies and riders subject to this subsection should be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, in no event shall the reserves for the long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit. In the development and calculation of reserves for policies and riders subject to this subsection, due regard shall be given to the applicable policy provisions, marketing methods, administrative procedures and all other considerations which have an impact on projected claim costs, including, but not limited to, the following:

1. Definition of insured events;

2. Covered long-term care facilities;

3. Existence of home convalescence care coverage;

4. Definition of facilities;

5. Existence or absence of barriers to eligibility;

6. Premium waiver provision;

7. Renewability;

8. Ability to raise premiums;

9. Marketing method;

10. Underwriting procedures;

11. Claims adjustment procedures;

12. Waiting period;

13. Maximum benefit;

14. Availability of eligible facilities;

15. Margins in claim costs;

16. Optional nature of benefit;

17. Delay in eligibility for benefit;

18. Inflation protection provisions; and

19. Guaranteed insurability option.

Any applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries.

B. When long-term care benefits are provided other than as in ~~Subsection~~ subsection A ~~above~~ of this section, reserves shall be determined in accordance with ~~subdivision 7 of § 38.2-3130 of the Code of Virginia~~ 14VAC5-320.

14VAC5-200-153. Premium rate schedule increases.

A. This section applies to any long-term care policy or certificate issued in this Commonwealth on or after October 1, 2003.

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

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

2. Certification by a qualified actuary that:

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

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

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

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

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

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

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

(4) For exceptional increases,

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

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

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

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

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

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

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

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

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

1. Exceptional increases shall provide that 70% of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;

2. Premium rate schedule increases shall be calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

a. The accumulated value of the initial earned premium times 58%;

b. Eighty-five percent of the accumulated value of prior premium rate schedule increases on an earned basis;

c. The present value of future projected initial earned premiums times 58%; and

d. Eighty-five percent of the present value of future projected premiums not in subdivision 2 c of this subsection on an earned basis;

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

4. All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as specified in ~~§ 38.2-3132 of the Code of Virginia~~ 14VAC5-320. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

D. For each rate increase that is implemented, the insurer shall file for approval by the commission updated projections, as defined in subdivision B 3 a of this section, annually for the next three years and include a comparison of actual results to projected values. The commission may extend the period to greater than three years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in subsection K of this section, the projections required by subdivision B 3 a of this section shall be provided to the policyholder in lieu of filing with the commission.

E. If any increased premium rate in the revised premium rate schedule is greater than 200% of the comparable rate in the initial premium schedule, the premiums exceeding 200% shall be clearly identified and lifetime projections, as defined

in subdivision B 3 a of this section, shall be filed for approval by the commission every five years following the end of the required period in subsection D of this section. For group insurance policies that meet the conditions in subsection K of this section, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commission.

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

a. Premium rate schedule adjustments; or

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

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

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

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

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

2. The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to subsection C of this section had the greater of the original anticipated lifetime loss ratio or 58% been used in the calculations described in subdivisions C 2 a and c of this section.

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

a. The rate increase is not the first rate increase requested for the specific policy form or forms;

b. The rate increase is not an exceptional increase; and

c. The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

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

a. The offer shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. Policy illustrations as required by ~~14VAC5-40~~ 14VAC5-41; and

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

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

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

b. A description of the basis for the reserves;

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

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

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

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

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

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

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

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

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

14VAC5-310-10. Purpose.

The purpose of this chapter (14VAC5-310) is to prescribe:

1. Requirements for statements of actuarial opinion that are to be submitted in accordance with § ~~38.2-3127.1~~ 38.2-1367 of the Code of Virginia, and for memoranda in support thereof;

2. Rules applicable to the appointment of an appointed actuary; and

3. Guidance as to the meaning of "adequacy of reserves."

14VAC5-310-20. Authority; effective date.

This chapter (14VAC5-310) is adopted and promulgated by the commission pursuant to §§ 12.1-13, 38.2-223, and ~~38.2-3127.1~~ 38.2-1367 of the Code of Virginia. This chapter will take effect for annual statements for the year-ending December 31, 1992. Except as otherwise specifically provided, revisions to this chapter shall be effective upon adoption by the commission and applicable as to annual statements and actuarial opinions, memoranda, and statements of reserves filed with the commission for periods ending on or after December 31 of the year in which the revision is adopted.

14VAC5-310-30. Scope.

A. This chapter (14VAC5-310) shall apply to all companies subject to the provisions of § ~~38.2-3127.1~~ 38.2-1367 of the Code of Virginia, including fraternal benefit societies licensed under Chapter 41 (§ 38.2-4100 et seq.) of Title 38.2 and all other companies licensed under Title 38.2 of the Code of Virginia to write and reinsure policies or agreements providing any form of life, life insurance, or annuity benefits as those terms are defined in §§ 38.2-102 through 38.2-107.1 of the Code of Virginia and also to any life insurer authorized to write or reinsure accident and sickness insurance as defined in § 38.2-109 of the Code of Virginia.

B. This chapter shall be applied in a manner that allows the appointed actuary to utilize professional judgment in performing the asset analysis and developing the actuarial opinion and supporting memoranda, consistent with relevant actuarial standards of practice unless the commission determines particular specifications are necessary for an acceptable opinion to be rendered relative to the adequacy of reserves and related items. Particular specifications, including specific methods of actuarial analysis and actuarial assumptions, may be promulgated by rule or order of the commission or by an administrative letter issued by the Commissioner of Insurance.

C. This chapter, as reflected in rules adopted by the commission by order entered November 5, 1992, in Case No. INS920377, shall be applicable to all annual statements filed with the commission on or after December 15, 1992, and before December 31, 2003. On and after December 31, 2003, a statement of opinion on the adequacy of the reserves and related actuarial items based on an asset adequacy analysis in accordance with 14VAC5-310-80, and a memorandum in support thereof in accordance with 14VAC5-310-90, shall be required each year in accordance with rules as revised and adopted by order of the commission entered in Case No. INS-2003-00165.

14VAC5-310-40. Definitions.

As used in this chapter unless the context clearly indicates otherwise:

"Actuarial opinion" means the opinion of an appointed actuary regarding the adequacy of reserves and related actuarial items based on an asset adequacy analysis in accordance with 14VAC5-310-80 and with applicable Actuarial Standards of Practice.

"Actuarial Standards Board" means the board established by the American Academy of Actuaries to develop and promulgate standards of actuarial practice.

"Annual statement" means that statement required by § 38.2-1300 of the Code of Virginia to be filed by the company with the commission annually.

"Appointed actuary" means any individual who is appointed or retained in accordance with the requirements set forth in 14VAC5-310-50 C to provide the actuarial opinion and supporting memorandum as required by § ~~38.2-3127.1~~ 38.2-1367 of the Code of Virginia.

"Asset adequacy analysis" means an analysis that meets the standards and other requirements referred to in 14VAC5-310-50 D.

"Commission" means the Virginia State Corporation Commission.

"Commissioner" means the Commissioner of Insurance in Virginia unless specific reference is made to another state, in which case "commissioner" means the Insurance Commissioner, Director, Superintendent or other supervising regulatory official of a given state who is responsible for administering the insurance laws of that state.

"Company" means a life insurer, company or fraternal benefit society subject to the provisions of this chapter.

"NAIC" means the National Association of Insurance Commissioners.

"Qualified actuary" means any individual who meets the requirements set forth in 14VAC5-310-50 B.

14VAC5-310-50. General requirements for actuarial opinions.

A. The following requirements apply to all companies submitting a statement of actuarial opinion in compliance with § ~~38.2-3127.1~~ 38.2-1367 of the Code of Virginia.

1. There is to be included on or attached to page 1 of the annual statement for each year ending on or after December 31, 1992, the statement of an appointed actuary, entitled "Statement of Actuarial Opinion," setting forth an opinion relating to reserves and related actuarial items held in support of policies and contracts, in accordance with 14VAC5-310-80.

2. Upon written request by the company, the commission may grant an extension of the date for submission of the statement of actuarial opinion.

B. A "qualified actuary" is an individual who:

1. Is a member in good standing of the American Academy of Actuaries;

2. Is qualified to sign statements of actuarial opinion for life and health insurance company annual statements in accordance with the American Academy of Actuaries qualification standards for actuaries signing such statements;

3. Is familiar with the valuation requirements applicable to life and health insurance companies;

4. Has not been found by the commission (or if so found has subsequently been reinstated as a qualified actuary), following appropriate notice and hearing, to have:

a. Violated any provision of, or any obligation imposed by Title 38.2 of the Code of Virginia or other law in the course of his dealings as a qualified actuary;

b. Been found guilty of fraudulent or dishonest practices;

c. Demonstrated his incompetency, lack of cooperation, or untrustworthiness to act as a qualified actuary;

d. Submitted to the commission during the past five years, pursuant to this chapter, an actuarial opinion or memorandum that the commission rejected because it did not meet the provisions of this chapter, including standards set by the Actuarial Standards Board; or

e. Resigned or been removed as an actuary within the past five years as a result of acts or omissions indicated in any adverse report on examination or as a result of failure to adhere to generally acceptable actuarial standards; and

5. Has not failed to notify the commission of any action taken by the commissioner of any other state similar to that under subdivision 4 of this subsection.

C. An "appointed actuary" is a qualified actuary who is appointed or retained to prepare the statement of actuarial opinion required by this chapter, either directly by or by the authority of the board of directors through an executive officer of the company other than the qualified actuary. The

company shall give the commission timely written notice of the name, title (and, in the case of a consulting actuary, the name of the firm) and manner of appointment or retention of each person appointed or retained by the company as an appointed actuary and shall state in such notice that the person meets the requirements set forth in 14VAC5-310-50 B. Once notice is furnished, no further notice is required with respect to this person, provided that the company shall give the commission timely written notice in the event the actuary ceases to be appointed or retained as an appointed actuary or to meet the requirements set forth in 14VAC5-310-50 B. If any person appointed or retained as an appointed actuary replaces a previously appointed actuary, the notice shall so state and give the reasons for replacement.

D. The asset adequacy analysis required by this chapter shall:

1. Conform to the Actuarial Standards of Practice as promulgated from time to time by the Actuarial Standards Board and on any additional standards under this chapter, which standards are to form the basis of the statement of actuarial opinion in accordance with ~~5~~ this chapter; and

2. Be based on methods of analysis as are deemed appropriate for such purposes by the Actuarial Standards Board.

E. Liabilities shall be covered in conformity with the following:

1. Under authority of § ~~38.2-3127.1~~ 38.2-1367 of the Code of Virginia, the statement of actuarial opinion shall apply to all in-force business on the statement date, whether directly issued or assumed, regardless of when or where issued~~,~~ (e.g., reserves reportable for 2002 in Exhibits 5, 5A, 6, and 7 of the NAIC annual statement for life insurers; claim liabilities reported in Exhibit 8 (2002) in Part I of the life insurer's annual statement, and equivalent items in any separate account statement, or other annual financial statements filed pursuant to § 38.2-1300, 38.2-1301 or 38.2-4126 of the Code of Virginia).

2. If the appointed actuary determines as the result of asset adequacy analysis that a reserve should be held in addition to the aggregate reserve held by the company and calculated in accordance with methods set forth in § 38.2-1311, 38.2-3923, 38.2-4010, 38.2-4011, or § 38.2-4125 of the Code of Virginia; Article ~~3 (§ 38.2-3136 et seq.)~~ 10 (§ 38.2-1365 et seq.) of Chapter ~~31~~ 13 of Title 38.2 of the Code of Virginia; a rule or regulation of the commission applicable to the company; or any additional or further guidance provided by the NAIC Accounting Practices and Procedures Manual, whether in a Statement of Statutory Accounting Principle or in an actuarial guideline or other appendix, the company shall establish the additional reserve.

3. Additional reserves established under subdivision 2 of this subsection and deemed not necessary in subsequent years may be released. Any amounts released shall be disclosed in the actuarial opinion for the applicable year. The release of such reserves would not be deemed an adoption of a lower standard of valuation.

14VAC5-310-90. Description of actuarial memorandum issued for an asset adequacy analysis and regulatory asset adequacy issues summary.

A. The following general provisions shall apply with respect to the preparation and submission of the asset adequacy memorandum required by § ~~38.2-3127.1~~ 38.2-1367 of the Code of Virginia.

1. In accordance with § ~~38.2-3127.1~~ 38.2-1367 of the Code of Virginia, the appointed actuary shall prepare a memorandum to the company describing the analysis done in support of his opinion regarding the reserves. The memorandum shall be made available for examination by the commission upon its request but shall be returned to the company after such examination and shall not be considered a record of the Bureau of Insurance or subject to automatic filing with the commission.

2. In preparing the memorandum, the appointed actuary may rely on, and include as a part of his memorandum, memoranda prepared and signed by other actuaries who are qualified within the meaning of 14VAC5-310-50 B, with respect to the areas covered in such memoranda, and so state in their memoranda.

3. If the commission requests a memorandum and no such memorandum exists or if the commission finds that the analysis described in the memorandum fails to meet the standards of the Actuarial Standards Board or the standards and requirements of this chapter, the commission may designate a qualified actuary to review the opinion and prepare such supporting memorandum as is required for review. The reasonable and necessary expense of the independent review shall be paid by the company but shall be directed and controlled by the commission.

4. The reviewing actuary shall have the same status as an examiner for purposes of obtaining data from the company and the work papers and documentation of the reviewing actuary shall be retained by the commission; however, any information provided by the company to the reviewing actuary and included in the work papers shall be considered as material provided by the company to the commission and shall be kept confidential to the same extent as is prescribed by law with respect to other material provided by the company to the commission pursuant to the statute governing this chapter. The reviewing actuary shall not be an employee of a consulting firm involved with the preparation of any prior memorandum or opinion for the insurer pursuant to this chapter for any one of the current year or the preceding three years.

5. In accordance with § ~~38.2-3127.1~~ 38.2-1367 of the Code of Virginia, the appointed actuary shall prepare a regulatory asset adequacy issues summary, the contents of which are specified in subsection C of this section. The

regulatory asset adequacy issues summary shall be submitted no later than March 15 of the year following the year for which a statement of actuarial opinion based on asset adequacy is required. The regulatory asset adequacy issues summary is to be kept confidential to the same extent and under the same conditions as the actuarial memorandum.

B. A section of the memorandum shall document asset adequacy testing by demonstrating that the analysis has been done in accordance with the standards for asset adequacy referred to in 14VAC5-310-50 D and any additional standards under this chapter. It shall specify:

1. For reserves:

a. Product descriptions including market description, underwriting and other aspects of a risk profile, and the specific risks the appointed actuary deems significant;

b. Source of liability in force;

c. Reserve method and basis;

d. Investment reserves;

e. Reinsurance arrangements;

f. Identification of any explicit or implied guarantees made by the general account in support of benefits provided through a separate account policy or contract and the methods used by the appointed actuary to provide for the guarantees in the asset adequacy analysis; and

g. Documentation of assumptions to test reserves for (i) lapse rates, whether base or excess, (ii) interest crediting rate strategy, (iii) mortality, (iv) policyholder dividend strategy, (v) competitor or market interest rate, (vi) annuitization rates, (vii) commission and expenses, and (viii) morbidity.

The documentation of the assumptions shall be such that an actuary reviewing the actuarial memorandum could form a conclusion as to the reasonableness of the assumption.

2. For assets:

a. Portfolio descriptions, including a risk profile disclosing the quality, distribution and types of assets;

b. Investment and disinvestment assumptions;

c. Source of asset data;

d. Asset valuation bases; and

e. Documentation of assumptions made for (i) default costs, (ii) bond call function, (iii) mortgage prepayment function, (iv) determining market value for assets sold due to disinvestment strategy, and (v) determining yield on assets acquired through the investment strategy.

The documentation of the assumptions shall be such that an actuary reviewing the actuarial memorandum could form a conclusion as to the reasonableness of the assumption.

3. For the analysis basis:

a. Methodology;

b. Rationale for inclusion or exclusion of different blocks of business and how pertinent risks were analyzed;

c. Rationale for degree of rigor in analyzing different blocks of business, including the rationale for the level of "materiality" that was used in determining how rigorously to analyze different blocks of business;

d. Criteria for determining asset adequacy, including in the criteria the precise basis for determining if assets are adequate to cover reserves under "moderately adverse conditions" or other conditions as specified in relevant actuarial standards of practice; and

e. Whether the impact of federal income taxes was considered and the method of treating reinsurance in the asset adequacy analysis.

4. Summary of material changes in methods, procedures, or assumptions from prior year's asset adequacy analysis;

5. Summary of results; and

6. Conclusion.

C. The regulatory asset adequacy issues summary shall contain the name of the company for which the regulatory asset adequacy issues summary is being supplied and shall be signed and dated by the appointed actuary rendering the actuarial opinion. The regulatory asset adequacy issues summary also shall include each of the following:

1. Descriptions of the scenarios tested, including whether those scenarios are stochastic or deterministic, and the sensitivity testing done relative to those scenarios. If negative ending surplus results under certain tests in the aggregate, the actuary should describe those tests and the amount of additional reserve as of the valuation date which, if held, would eliminate the negative aggregate surplus values. Ending surplus values shall be determined by either extending the projection period until the in-force and associated assets and liabilities at the end of the projection period are immaterial or by adjusting the surplus amount at the end of the projection period by an amount that appropriately estimates the value that reasonably can be expected to arise from the assets and liabilities remaining in force;

2. The extent to which the appointed actuary uses assumptions in the asset adequacy analysis that are materially different from the assumptions used in the previous asset adequacy analysis;

3. The amount of reserves and the identity of the product lines that had been subjected to asset adequacy analysis in the prior opinion but were not subject to analysis for the current opinion;

4. Comments on any interim results that may be of significant concern to the appointed actuary. For example, the impact of the insufficiency of assets to support the

payment of benefits and expenses and the establishment of statutory reserves during one or more interim periods;

5. The methods used by the actuary to recognize the impact of reinsurance on the company's cash flows, including both assets and liabilities, under each of the scenarios tested; and

6. Whether the actuary has been satisfied that all options whether explicit or embedded, in any asset or liability, including but not limited to those affecting cash flows embedded in fixed income securities, and equity-like features in any investments have been appropriately considered in the asset adequacy analysis.

D. The actuarial methods, considerations, and analyses shall conform to appropriate standards of practice and the memorandum shall include the following statement:

"Actuarial methods, considerations and analyses used in the preparation of this memorandum conform to the appropriate Standards of Practice as promulgated by the Actuarial Standards Board, which standards form the basis for this memorandum."

E. An appropriate allocation of assets in the amount of Interest Maintenance Reserve (IMR), whether positive or negative, shall be used in any asset adequacy analysis. Analysis of risks regarding asset default shall include an appropriate allocation of assets supporting the Asset Valuation Reserve (AVR); these AVR assets shall not be applied for any other risks with respect to reserve adequacy. Analysis of these and other risks shall include assets supporting other mandatory or voluntary reserves available to the extent not used for risk analysis and reserve support. The amount of the assets used for the AVR shall be disclosed in the Table of Reserves and Liabilities of the opinion and in the memorandum. The method used for selecting particular assets or allocated portions of assets shall be disclosed in the memorandum.

14VAC5-319-10. Definitions.

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

"1980 CSO valuation tables" means the Commissioners' 1980 Standard Ordinary Mortality Table (1980 CSO Table) without 10-year selection factors, incorporated into the 1980 amendments to the NAIC Standard Valuation Law, and variations of the 1980 CSO Table approved by the NAIC, such as the smoker and nonsmoker versions approved in December 1983.

"Basic reserves" means reserves calculated in accordance with § ~~38.2-3137~~ 38.2-1372 of the Code of Virginia.

"Commission" means the State Corporation Commission when acting pursuant to or in accordance with Title 38.2 of the Code of Virginia.

"Contract segmentation method" means the method of dividing the period from issue to mandatory expiration of a policy into successive segments, with the length of each segment being defined as the period from the end of the prior segment (from policy inception, for the first segment) to the end of the latest policy year as determined below. All calculations are made using the 1980 CSO valuation tables, as defined in this section, (or any other valuation mortality table adopted by the NAIC after January 1, 2000, and promulgated by regulation by the commission for this purpose) and, if elected, the optional minimum mortality standard for deficiency reserves stipulated in 14VAC5-319-40 B.

The length of a particular contract segment shall be set equal to the minimum of the value t for which G_t is greater than R_t (if G_t never exceeds R_t, the segment length is deemed to be the number of years from the beginning of the segment to the mandatory expiration date of the policy), where G_t and R_t are defined as follows:

$$G_t = \frac{GP_{x+k+t}}{GP_{x+k+t-1}}$$

where:

x = original issue age;

k = the number of years from the date of issue to the beginning of the segment;

t = 1, 2,...; t is reset to 1 at the beginning of each segment; and

$GP_{x+k+t-1}$ = Guaranteed gross premium per $1,000 of face amount for year t of the segment, ignoring policy fees only if level for the premium paying period of the policy.

$$R_t = \frac{q_{x+k+t}}{q_{x+k+t-1}}$$

where:

R_t may be increased or decreased by 1.0% in any policy year, at the company's option, but R_t shall not be less than one; and

x, k and t are as defined above; and

$q_{x+k+t-1}$ = valuation mortality rate for deficiency reserves in policy year k+t but using the mortality of 14VAC5-319-40 B 2 if 14VAC5-319-40 B 3 is elected for deficiency reserves. However, if GP_{x+k+t} is greater than 0 and $GP_{x+k+t-1}$ is equal to 0, G_t shall be deemed to be 1,000. If GP_{x+k+t} and $GP_{x+k+t-1}$ are both equal to 0, G_t shall be deemed to be 0.

"Deficiency reserves" means the excess, if greater than 0, of (i) minimum reserves calculated in accordance with § ~~38.2-3141~~ 38.2-1376 of the Code of Virginia over (ii) basic reserves.

"Guaranteed gross premiums" means the premiums under a policy of life insurance that are guaranteed and determined at issue.

"Maximum valuation interest rates" means the interest rates defined in § ~~38.2-3130~~ 38.2-1371 of the Code of Virginia that

are to be used in determining the minimum standard for the valuation of life insurance policies.

"NAIC" means the National Association of Insurance Commissioners.

"Scheduled gross premium" means the smallest illustrated gross premium at issue for other than universal life insurance policies. For universal life insurance policies, scheduled gross premium means the smallest specified premium described in 14VAC5-319-60 A 3 or, if none is so described, the minimum premium described in 14VAC5-319-60 A 4.

"Segmented reserves" means reserves, calculated using segments produced by the contract segmentation method, equal to the present value of all future guaranteed benefits less the present value of all future net premiums to the mandatory expiration of a policy, where the net premiums within each segment are a uniform percentage of the respective guaranteed gross premiums within the segment. The uniform percentage for each segment is such that, at the beginning of the segment, the present value of the net premiums within the segment equals:

1. The present value of the death benefits within the segment, plus

2. The present value of any unusual guaranteed cash value (see 14VAC5-319-50 D) occurring at the end of the segment, less

3. Any unusual guaranteed cash value occurring at the start of the segment, plus

4. For the first segment only, the excess of subdivision 4 a over subdivision 4 b of this definition, as follows:

a. A net level annual premium equal to the present value, at the date of issue, of the benefits provided for in the first segment after the first policy year, divided by the present value, at the date of issue, of an annuity of one per year payable on the first and each subsequent anniversary within the first segment on which a premium falls due. However, the net level annual premium shall not exceed the net level annual premium on the 19-year premium whole life plan of insurance of the same renewal year equivalent level amount at an age one year higher than the age at issue of the policy.

b. A net one-year term premium for the benefits provided for in the first policy year.

The length of each segment is determined by the "contract segmentation method," as defined in this section.

The interest rates used in the present value calculations for any policy may not exceed the maximum valuation interest rate, determined with a guarantee duration equal to the sum of the lengths of all segments of the policy.

For both basic reserves and deficiency reserves computed by the segmented method, present values shall include future benefits and net premiums in the current segment and in all subsequent segments.

"Tabular cost of insurance" means the net single premium at the beginning of a policy year for one-year term insurance in the amount of the guaranteed death benefit in that policy year.

"Ten-year select mortality factors" means the select factors adopted by the NAIC with the 1980 amendments to the NAIC Standard Valuation Law.

"This regulation" means Chapter 319 of Title 14 of the Virginia Administrative Code (14VAC5-319~~-10 et seq.~~), which also shall be known as the commission's Rules Establishing Minimum Valuation and Reserve Standards for Life Insurance Policies.

"Twenty-year select mortality factors" means the select factors adopted by the NAIC as part of the Valuation of Life Insurance Policies Model Regulation and shown in the tables in 14VAC5-319-70.

"Unitary reserves" means the present value of all future guaranteed benefits less the present value of all future modified net premiums, where:

1. Guaranteed benefits and modified net premiums are considered to the mandatory expiration of the policy; and

2. Modified net premiums are a uniform percentage of the respective guaranteed gross premiums, where the uniform percentage is such that, at issue, the present value of the net premiums equals the present value of all death benefits and pure endowments, plus the excess of subdivision 2 a over subdivision 2 b of this definition, as follows:

a. A net level annual premium equal to the present value, at the date of issue, of the benefits provided for after the first policy year, divided by the present value, at the date of issue, of an annuity of one per year payable on the first and each subsequent anniversary of the policy on which a premium falls due. However, the net level annual premium shall not exceed the net level annual premium on the 19-year premium whole life plan of insurance of the same renewal year equivalent level amount at an age one year higher than the age at issue of the policy.

b. A net one-year term premium for the benefits provided for in the first policy year.

The interest rates used in the present value calculations for any policy may not exceed the maximum valuation interest rate, determined with a guarantee duration equal to the length from issue to the mandatory expiration of the policy.

"Universal life insurance policy" means any individual life insurance policy under the provisions of which separately identified interest credits (other than in connection with dividend accumulations, premium deposit funds or other supplementary accounts) and mortality or expense charges are made to the policy.

"YRT" means yearly renewable term.

14VAC5-321-10. Authority.

This chapter is promulgated by the commission, pursuant to § 38.2-223 of the Code of Virginia and in accordance with §§ ~~38.2-3130~~ 38.2-1369, 38.2-3206 through 38.2-3209, and 38.2-4120 of the Code of Virginia and 14VAC5-319-40, to approve, recognize, permit, and prescribe the use of the 2001 Commissioners Standard Ordinary (CSO) Mortality Table by and for insurers transacting the business of insurance in this Commonwealth.

14VAC5-321-30. 2001 CSO Mortality Table.

A. At the election of the insurer for any one or more specified plans of insurance and subject to the conditions stated in this chapter, the 2001 CSO Mortality Table may be used as the minimum standard for policies issued on or after January 1, 2004, and before the date specified in subsection B of this section to which subdivision 1 of § ~~38.2-3130~~ 38.2-1369 and § 38.2-3209 of the Code of Virginia are applicable. If the insurer elects to use the 2001 CSO Mortality Table, it shall do so for both valuation and nonforfeiture purposes.

B. Subject to the conditions stated in this chapter, the 2001 CSO Mortality Table shall be used in determining minimum standards for policies issued on and after January 1, 2009, to which subdivision 1 of § ~~38.2-3130~~ 38.2-1369 and § 38.2-3209 of the Code of Virginia are applicable.

C. A table from the 2001 CSO Preferred Class Structure Mortality Table used in place of a 2001 CSO Mortality Table, pursuant to the requirements of 14VAC5-322, will be treated as part of the 2001 CSO Mortality Table only for purposes of reserve valuation pursuant to the requirements of this chapter.

14VAC5-321-40. Conditions.

A. For policies issued on or after July 1, 2004, with each plan of insurance with separate rates for smokers and nonsmokers an insurer may use:

1. Composite mortality tables to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits;

2. Smoker and nonsmoker mortality tables to determine the valuation net premiums and additional minimum reserves, if any, required by § ~~38.2-3141~~ 38.2-1376 of the Code of Virginia and use composite mortality tables to determine the basic minimum reserves, minimum cash surrender values, and amounts of paid-up nonforfeiture benefits; or

3. Smoker and nonsmoker mortality tables to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits.

B. For policies issued on or after July 1, 2004, with plans of insurance without separate rates for smokers and nonsmokers the composite mortality tables shall be used.

C. For the purpose of determining minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits, the 2001 CSO Mortality Table may, at the option of the insurer for each such plan of insurance, be used in its ultimate or select and ultimate form, subject to the restrictions of 14VAC5-321-50 and 14VAC5-319 relative to use of the select and ultimate form.

D. When the 2001 CSO Mortality Table is the minimum reserve standard for any plan for an insurer, any actuarial opinion in the annual statement filed with the commission shall be based on an asset adequacy analysis that meets the standards and satisfies requirements for an asset adequacy analysis performed pursuant to subdivision A 2 of § ~~38.2-3127.1 B~~ 38.2-1367 of the Code of Virginia and rules governing actuarial opinions and memoranda at 14VAC5-310.

14VAC5-322-10. Authority.

This chapter is promulgated by the commission, pursuant to § 38.2-223 of the Code of Virginia and in accordance with § ~~38.2-3130~~ 38.2-1369 of the Code of Virginia and 14VAC5-319-40, to approve, recognize, permit, and prescribe the use of the 2001 Commissioners Standard Ordinary (CSO) Preferred Class Structure Mortality Table by and for insurers transacting the business of insurance in this Commonwealth.

14VAC5-323-10. Authority.

This chapter is promulgated by the commission, pursuant to § 38.2-223 of the Code of Virginia and in accordance with §§ ~~38.2-3130~~ 38.2-1369, 38.2-3206 through 38.2-3209, and 38.2-4120 of the Code of Virginia and 14VAC5-319-40, to approve, recognize, permit, and prescribe the use of the 1980 Commissioners Standard Ordinary (CSO) Life Valuation Mortality Table for use in determining the minimum standard of valuation of reserves and the minimum standard nonforfeiture values for insurers offering preneed insurance in this Commonwealth.

14VAC5-323-40. Minimum valuation interest rate standards.

A. The interest rates used in determining the minimum standard for valuation of preneed insurance shall be the calendar year statutory valuation interest rates as defined in ~~§§ 38.2-3133 through 38.2-3136~~ § 38.2-1371 of the Code of Virginia.

B. The interest rates used in determining the minimum standard for nonforfeiture values for preneed insurance shall be the calendar year statutory nonforfeiture interest rates as defined in § 38.2-3209 of the Code of Virginia.

14VAC5-323-50. Minimum valuation method standards.

A. The method used in determining the standard for the minimum valuation of reserves of preneed insurance shall be the method defined in §§ ~~38.2-3129~~ 38.2-1368 and ~~38.2-3130~~ 38.2-1369 of the Code of Virginia.

B. The method used in determining the standard for the minimum nonforfeiture values for preneed insurance shall be the method defined in § 38.2-3209 of the Code of Virginia.

VA.R. Doc. No. R15-4085; Filed December 3, 2014, 11:57 a.m.

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARD OF MEDICINE

Fast-Track Regulation

Title of Regulation: **18VAC85-50. Regulations Governing the Practice of Physician Assistants (adding 18VAC85-50-117).**

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

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: January 28, 2015.

Effective Date: February 13, 2015.

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

Basis: Chapter 24 (§ 54.1-2400 et seq.) of Title 54.1 of the Code of Virginia establishes the general powers and duties of health regulatory boards including the responsibility to promulgate regulations. Section 54.1-2400 provides that the board has the power to promulgate regulations in accordance with the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia) that are reasonable and necessary to administer effectively the regulatory system. Section 54.1-2952 provides that a licensed physician assistant who (i) is working under the supervision of a licensed doctor of medicine or osteopathy specializing in the field of radiology, (ii) has been trained in the proper use of equipment for the purpose of performing radiologic technology procedures consistent with board regulations, and (iii) has successfully completed the exam administered by the American Registry of Radiologic Technologists for physician assistants for the purpose of performing radiologic technology procedures may use fluoroscopy for guidance of diagnostic and therapeutic procedures.

Purpose: The purpose of the regulation is to establish the qualifications of a physician assistant who may use fluoroscopy for guidance of diagnostic and therapeutic procedures under the supervision of a physician specializing in the field of radiology. Fluoroscopy is a radiological procedure that is not within the usual scope of practice of a physician assistant. Therefore, additional education, training and testing are required to ensure minimal competency to perform the procedure. The goal of the amended regulation is to set qualifications that are consistent with those recommended by the national professional bodies for both radiologic technologists and physician assistants.

Fluoroscopy is a radiologic procedure that emits high levels of ionizing radiation and is used for diagnostic and therapeutic purposes. Performed improperly, flurorscopy can harm a patient or cause a misdiagnosis that can harm a patient. Since fluoroscopy is typically outside the scope of practice for physician assistants and not covered in their prelicensure educational programs and examinations, additional qualifications must be established to ensure minimal competency to perform the procedure with safety and effectiveness to protect the public health, welfare, and safety.

Rationale for Using Fast-Track Process: An emergency regulation became effective on November 12, 2013, and a Notice of Intended Regulatory Action was published for the replacement of the emergency. During the 30-day comment period, there was no comment, and there have been no issues reported by providers.

Substance: 18VAC85-50-117 sets out qualifications by which a physician assistant working under the supervision of a licensed doctor of medicine or osteopathy specializing in the field of radiology is authorized to use fluoroscopy for guidance of diagnostic and therapeutic procedures provided such activity is specified in his protocol. Those qualifications are (i) completion of at least 40 hours of structured didactic educational instruction and at least 40 hours of supervised clinical experience as set forth in the Fluoroscopy Educational Framework for the Physician Assistant created by the American Academy of Physician Assistants and the American Registry of Radiologic Technologists (ARRT) and (ii) successful passage of the ARRT Fluoroscopy Examination.

Issues: The primary advantage is a very modest expansion of practice by mid-level providers, specifically physician assistants working under the supervision of radiologists. There are no disadvantages; there is adequate education and training to assure minimal competency for safe and effective practice. There are no advantages or disadvantages to the Commonwealth.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. Pursuant to Chapter 81 of the 2012 Acts of the Assembly, the Board of Medicine (Board) proposes to amend its Regulations Governing the Practice of Physician Assistants so that physician assistants who have completed specified training may use fluoroscopy.[1] This proposed amendment will replace identical language promulgated under emergency regulation provisions that will expire May 11, 2015.

Result of Analysis. Benefits likely outweigh costs for this proposed regulatory change.

Estimated Economic Impact. Prior to a legislative change in 2012, only radiologists and licensed radiological technicians were authorized to use fluoroscopy. In 2012, the General Assembly passed a bill which extended the practice of

physician assistants so that they, too, could use fluoroscopy so long as they 1) work under the supervision of a doctor of medicine or osteopathy specializing in the field of radiology, 2) complete Board specified training and 3) successfully complete the fluoroscopy exam administered by the American Registry of Radiologic Technologists (ARRT). The Board proposes to require physician assistants to complete at least 40 hours of education and at least 40 hours of supervised clinical experience.[2]

Physician assistants who choose to pursue expanding their scope of practice to include the use of fluoroscopy will incur costs for completing the required training and for taking the fluoroscopy exam. The fee for the exam is $175; currently, there does not seem to be an estimate of what training will cost. In any case, physician assistants are unlikely to incur these costs if they do not think the benefits that they expect will accrue to them (in the form of greater job opportunities and/or higher salaries) justify the expense. If a significant number of physician assistants choose to become qualified to use fluoroscopy, the maximum capacity of fluoroscopy services may increase which might, in turn, lower the cost of those services.

Businesses and Entities Affected. Board staff reports that the Board currently licenses 2,774 physician assistants. Board staff does not know how many of these physician assistants currently work for radiologists or how many might choose to become qualified to use fluoroscopy. It is likely that the number of affected entities would be a small subset of the total number of physician assistants.

Localities Particularly Affected. No locality will be particularly affected by this proposed regulatory action.

Projected Impact on Employment. If a significant number of physician assistants choose to become qualified to use fluoroscopy, the maximum capacity of fluoroscopy services may increase which might, in turn, lower the cost of those services. If this happens, the quantity of fluoroscopy services demanded may increase and employment in jobs that use fluoroscopy may increase.

Effects on the Use and Value of Private Property. This regulatory action may increase the value of a physician assistant's license if becoming qualified to use fluoroscopy increases the wage that qualified individuals can command.

Small Businesses: Costs and Other Effects. No small businesses will incur costs on account of this regulatory action.

Small Businesses: Alternative Method that Minimizes Adverse Impact. No small businesses will incur costs on account of this regulatory action.

Real Estate Development Costs. This regulatory action will likely have no effect on real estate development costs in the Commonwealth.

Legal Mandate.

General: The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007.04 of the Code of Virginia and Executive Order Number 14 (2010). Section 2.2-4007.04 requires that such economic impact analyses determine the public benefits and costs of the proposed amendments. Further the report should include but not be limited to:

- the projected number of businesses or other entities to whom the proposed regulation would apply,
- the identity of any localities and types of businesses or other entities particularly affected,
- the projected number of persons and employment positions to be affected,
- the projected costs to affected businesses or entities to implement or comply with the regulation, and
- the impact on the use and value of private property.

Small Businesses: If the proposed regulation will have an adverse effect on small businesses, § 2.2-4007.04 requires that such economic impact analyses include:

- an identification and estimate of the number of small businesses subject to the proposed regulation,
- the projected reporting, recordkeeping, and other administrative costs required for small businesses to comply with the proposed regulation, including the type of professional skills necessary for preparing required reports and other documents,
- a statement of the probable effect of the proposed regulation on affected small businesses, and
- a description of any less intrusive or less costly alternative methods of achieving the purpose of the proposed regulation.

Additionally, pursuant to § 2.2-4007.1, if there is a finding that a proposed regulation may have an adverse impact on small business, the Joint Commission on Administrative Rules (JCAR) is notified at the time the proposed regulation is submitted to the Virginia Register of Regulations for publication. This analysis shall represent DPB's best estimate for the purposes of public review and comment on the proposed regulation.

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[1] Fluoroscopy, according to emedicine.medscape.com, is “a technique that employs x-rays to generate real-time still images or video of a patient's body. It is a commonly used medical technique that helps physicians with a wide variety of diagnostic and interventional procedures”.

2 The Board specified in the emergency regulation, and specifies in this action, that physician assistants who wish to expand their scope of practice to include the use of fluoroscopy must complete education and supervised practice as set forth in the Fluoroscopy Education Framework for the Physician Assistant by the American Academy of Physician Assistants (AAPA) and the American Society of Radiological Technologists (ASRT).

Agency's Response to Economic Impact Analysis: The Board of Medicine concurs with the economic impact analysis on 18VAC85-50.

Summary:

The regulation establishes the qualifications of a physician assistant who may use fluoroscopy for guidance of diagnostic and therapeutic procedures under the supervision of a licensed doctor of medicine or osteopathy specializing in the field of radiology. The additional education, training, and testing is consistent with the qualifications recommended by the American Academy of Physician Assistants and the American Society of Radiologic Technologists.

18VAC85-50-117. Authorization to use fluoroscopy.

A physician assistant working under the supervision of a licensed doctor of medicine or osteopathy specializing in the field of radiology is authorized to use fluoroscopy for guidance of diagnostic and therapeutic procedures provided such activity is specified in his protocol and he has met the following qualifications:

1. Completion of at least 40 hours of structured didactic educational instruction and at least 40 hours of supervised clinical experience as set forth in the Fluoroscopy Educational Framework for the Physician Assistant created by the American Academy of Physician Assistants (AAPA) and the American Society of Radiologic Technologists (ASRT); and

2. Successful passage of the American Registry of Radiologic Technologists (ARRT) Fluoroscopy Examination.

DOCUMENTS INCORPORATED BY REFERENCE (18VAC85-50)

Fluoroscopy Educational Framework for the Physician Assistant, December 2009, American Academy of Physician Assistants, 950 North Washington Street, Alexandria, VA 22314 and the American Society of Radiologic Technologists, 15000 Central Avenue, SE, Albuquerque, NM 87123

VA.R. Doc. No. R14-3348; Filed December 10, 2014, 11:43 a.m.

Fast-Track Regulation

Title of Regulation: **18VAC85-110. Regulations Governing the Practice of Licensed Acupuncturists (amending 18VAC85-110-50).**

Statutory Authority: §§ 54.1-2400 and 54.1-2956.9 of the Code of Virginia.

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: January 28, 2015.

Effective Date: February 13, 2015.

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

Basis: Chapter 24 (§ 54.1-2400 et seq.) of Title 54.1 of the Code of Virginia establishes the general powers and duties of health regulatory boards including the responsibility to promulgate regulations. Section 54.1-2956.10 requires the board to establish a testing program to determine the training and educational achievements of acupuncturists, or the board may accept other evidence such as successful completion of a national certification examination, experience, or completion of an approved training program in lieu of testing and establish this as a prerequisite for approval of the licensee's application.

Purpose: The purpose of the amendment is to allow graduates of acupuncture programs that have candidacy status from the Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM) to be licensed in Virginia. In order to achieve candidacy status, a program must meet the same academic criteria as an accredited program. Accreditation is granted after a program has demonstrated a sustained level of achievement and financial stability. Graduates of candidacy status programs take the same licensing examination as accredited programs and pass the examination at a similar rate. Therefore, there is evidence that such graduates have adequate education and training to assure minimal competency for safe and effective practice as licensed acupuncturists.

Rationale for Using Fast-Track Process: The board received a recommendation from the Advisory Board on Acupuncture to amend regulations by a fast-track action to accelerate the less restrictive change to the benefit of applicants and acupuncture schools opening in Virginia. Prior to adoption, the change was vetted with representatives of the National Certification Commission for Acupuncture and Oriental Medicine and the Acupuncture Society of Virginia to ensure that it was acceptable and not controversial.

Substance: An amendment to 18VAC85-110-50 will authorize the board to license an applicant from an acupuncture program or school in candidacy status for accreditation by ACAOM if the applicant has obtained the requisite hours of didactic education and clinical training.

Issues: The primary advantage of the amendment is a very modest increase in the number of applicants who will qualify for licensure in Virginia. There are no disadvantages; there is adequate education and training to assure minimal competency for safe and effective practice. There are no advantages or disadvantages to the Commonwealth. There will be a small number of practitioners who will be able to practice in Virginia rather than going to other states.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The Board of Medicine (Board) proposes to allow graduates of acupuncture programs that have candidacy status from the Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM) to be licensed in Virginia.

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

Estimated Economic Impact. In order to achieve candidacy status, acupuncture educational programs must meet the same academic criteria as accredited programs. Accreditation is granted after a program has demonstrated a sustained level of achievement and financial stability. Graduates of candidacy status programs take the same licensing examination as accredited programs and pass the examination at a similar rate.[1] Therefore, there is evidence that such graduates have adequate education and training to assure minimum competency for safe and effective practice as licensed acupuncturists.

There are 72 fully ACAOM accredited acupuncture educational programs, but none are in Virginia. There are three Virginia acupuncture educational programs in candidacy status.[2] The proposed amendment will allow graduates of these programs (who meet the other licensing criteria) to become licensed in Virginia. This will likely increase business for these three Virginia programs and will allow their graduates to practice and gain employment in the Commonwealth. Since as described above, there is evidence that graduates of these programs are likely as competent as graduates of fully accredited programs, the proposed change will be beneficial in that it will allow additional qualified acupuncturists to practice in Virginia and will remove an unnecessary burden for three Virginia businesses.

Businesses and Entities Affected. The proposed amendment affects acupuncture educational programs with candidacy status and their graduates. There are three Virginia acupuncture educational programs in candidacy status.[3]

Localities Particularly Affected. Two of the three Virginia acupuncture educational programs in candidacy status are in Fairfax County. The third is in the City of Alexandria.[4]

Projected Impact on Employment. The proposed amendment will likely increase the number of acupuncturists practicing in the Commonwealth.

Effects on the Use and Value of Private Property. The proposed amendment will likely increase the value of the three Virginia acupuncture educational programs in candidacy status, since earning one of their degrees would with the amendment permit licensure in Virginia.

Small Businesses: Costs and Other Effects. The proposed amendment will not increase costs for small businesses. The three Virginia acupuncture educational programs in candidacy status, likely all small businesses, will only benefit from the proposed amendment.

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

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

Legal Mandate.

General: The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007.04 of the Code of Virginia and Executive Order Number 14 (2010). Section 2.2-4007.04 requires that such economic impact analyses determine the public benefits and costs of the proposed amendments. Further the report should include but not be limited to:

- the projected number of businesses or other entities to whom the proposed regulatory action would apply,
- the identity of any localities and types of businesses or other entities particularly affected,
- the projected number of persons and employment positions to be affected,
- the projected costs to affected businesses or entities to implement or comply with the regulation, and
- the impact on the use and value of private property.

Small Businesses: If the proposed regulatory action will have an adverse effect on small businesses, § 2.2-4007.04 requires that such economic impact analyses include:

- an identification and estimate of the number of small businesses subject to the proposed regulation,
- the projected reporting, recordkeeping, and other administrative costs required for small businesses to comply with the proposed regulation, including the type of professional skills necessary for preparing required reports and other documents,
- a statement of the probable effect of the proposed regulation on affected small businesses, and
- a description of any less intrusive or less costly alternative methods of achieving the purpose of the proposed regulation.

Additionally, pursuant to § 2.2-4007.1, if there is a finding that a proposed regulation may have an adverse impact on small business, the Joint Commission on Administrative Rules (JCAR) is notified at the time the proposed regulation is submitted to the Virginia Register of Regulations for publication. This analysis shall represent DPB's best estimate for the purposes of public review and comment on the proposed regulation.

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[1] Source: Department of Health Professions

[2] Data from Accreditation Commission for Acupuncture and Oriental Medicine website (http://www.acaom.org/) accessed on April 15, 2014.

[3] Ibid.

[4] Ibid.

Agency's Response to Economic Impact Analysis: The Board of Medicine concurs with the economic impact analysis prepared by the Department of Planning and Budget for 18VAC85-110.

Summary:

The amendment permits the issuance of a license to an applicant who is a graduate of an acupuncture program or

school that is in candidacy status for accreditation by the Accreditation Commission for Acupuncture and Oriental Medicine if the applicant has obtained the requisite hours of didactic education and clinical training.

Part II
Requirements for Licensure

18VAC85-110-50. Educational requirements: graduates of approved institutions or programs in the United States.

A. Requirements for acupuncture education obtained prior to July 1, 1990, shall be as provided in this subsection.

1. An applicant applying for licensure to practice as an acupuncturist on the basis of successful completion of education in a school or college of acupuncture accredited by the ACAOM or other accrediting agencies approved by the Board of Medicine, which confers a degree or certificate in acupuncture in the United States, shall submit evidence of successful completion of an acupuncture course of study in an accredited school or college for acupuncture, providing evidence of not less than 1,000 hours of schooling in not less than a continuous 18-month period.

2. The studies shall include not less than 700 didactic hours and not less than 250 clinical hours. Additional hours may be in either didactic or clinical hours based upon the school or college curriculum.

B. Requirements for acupuncture education obtained after July 1, 1990, shall be as provided in this subsection.

An applicant applying for licensure to practice as a licensed acupuncturist on the basis of successful completion of education in a school or college for acupuncture accredited by ACAOM or any other accrediting agency approved by the Board of Medicine, which confers a degree or certificate in acupuncture in the United States, shall submit evidence of having a minimum of three academic years in length equivalent to 90 semester credit hours or 135 quarter credit hours.

One academic year means full-time study completed in four quarters, two semesters, or three trimesters. A full-time continuous study program shall be a concentrated educational process in acupuncture that requires individual study with assigned materials in a classroom or clinical setting.

C. Requirements for acupuncture education obtained after July 1, 1999, shall be as provided in this subsection. An applicant applying for licensure to practice as a licensed acupuncturist on the basis of successful completion of education in a school or college for acupuncture accredited by ACAOM or any other accrediting agency approved by the Board of Medicine, which confers a degree or certificate in acupuncture in the United States, shall submit evidence of having a minimum of 1,725 hours of entry-level acupuncture education to include at least 1,000 didactic hours and 500 clinical hours. Clinical hours may include observation, as well as internship or treatment hours; the remaining 225 hours may be earned as either didactic or clinical. Correspondence programs or courses in acupuncture are excluded and may not be used to meet the requirements for acupuncture education.

D. Requirements for acupuncture education obtained after February 1, 2011, shall be as provided in this subsection. An applicant applying for licensure to practice as a licensed acupuncturist on the basis of successful completion of education in a school or college for acupuncture accredited by ACAOM or any other accrediting agency approved by the Board of Medicine, which confers a degree or certificate in acupuncture in the United States, shall submit evidence of having a minimum of 1,905 hours of entry-level acupuncture education to include at least 1,155 didactic hours and 660 clinical hours. Clinical hours may include observation, as well as internship or treatment hours; the remaining 90 hours may be earned as either didactic or clinical hours. Correspondence programs or courses in acupuncture are excluded and may not be used to meet the requirements for acupuncture education.

E. An applicant from an acupuncture program in a school or college that has achieved candidacy status for accreditation by ACAOM shall be eligible for licensure provided the program ~~has subsequently been granted accreditation within three years of the applicant's graduation~~ meets the applicable requirements of subsection A, B, C, or D of this section, with the exception of full ACAOM accreditation.

VA.R. Doc. No. R15-3971; Filed December 10, 2014, 11:44 a.m.

Fast-Track Regulation

Title of Regulation: **18VAC85-160. Regulations Governing the Registration of Surgical Assistants and Surgical Technologists (adding 18VAC85-160-10 through 18VAC85-160-50).**

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

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: January 28, 2015.

Effective Date: February 13, 2015.

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

Basis: Regulations are promulgated under the general authority of Chapter 24 (§ 54.1-2400 et seq.) of Title 54.1 of the Code of Virginia. Section 54.1-2400 provides the Board of Medicine the authority to establish qualifications for registration, register qualified applicants, establish schedules for renewal, levy and collect fees, and promulgate regulations to administer the regulatory system. In addition, Chapter 531 of the 2014 Acts of the Assembly enacted §§ 54.1-2956.12 and 54.1-2956.13 of the Code of Virginia, mandating that the board register technologists and assistants who possess certain credentials.

Purpose: The purpose of the regulation is to state general provisions for registration, including fees for applicants and renewal of registration and to set out the qualifications for registration. While the registration is voluntary for surgical assistants and surgical technologists, the public and potential employers will be able to use the information for greater assurance that the person is qualified to practice with safety and minimal competency, which protects the public health, welfare, and safety.

Rationale for Using Fast-Track Process: Since this regulation sets out the qualifications for registration already established in the Code of Virginia by Chapter 531 of the 2014 Acts of Assembly, it will not be controversial. Unless final regulations are in effect prior to July 1, 2015, the grandfathering provision for those individuals who were practicing prior to July 1, 2014, cannot be implemented and an avenue for registration will be closed to applicants. Therefore, the board determined that the fast-track action was necessary and appropriate.

Substance: Regulations establish requirements for registrants to maintain a current name and address, fees for application and renewal, and qualifications for registration as a surgical technologist or surgical assistant.

Issues: The primary advantage to the public is a registry of practitioners who hold credentials as a surgical technologist or surgical assistant. There is no requirement for registration in order to practice in the field, so hospitals can continue to hire and train persons on the job. There are no disadvantages. There are no advantages or disadvantages to the agency or the Commonwealth.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. Pursuant to Chapter 531 of the 2014 Act of the Assembly, the Board of Medicine (Board) proposes to promulgate new regulations for the registration of surgical assistants and surgical technologists.

Result of Analysis. There is insufficient information to ascertain whether benefits will outweigh costs for this regulatory program.

Estimated Economic Impact. Currently, surgical assistants and surgical technologists are not registered or licensed by the Commonwealth of Virginia. The General Assembly passed legislation this year that will set up certain criteria that individuals can meet in order to register with the Board of Medicine. Chapter 531 will not require all surgical assistants and surgical technologists to register but does require that they not hold themselves out as registered surgical technologists or registered surgical assistants unless they have taken steps to actually register with the Board. Chapter 531 will require that surgical technologists either 1) hold a certification in their field from the National Board of Surgical Technology and Surgical Assisting, 2) have completed an appropriate training program while serving as a member of any branch of the armed forces of the United States, or 3) have practiced in the field of registration any time in the six months prior to July 1, 2014 (so long as they register with the Board by July 1, 2015). Chapter 531 also will require that surgical assistants either 1) hold a certification in their field from the National Board of Surgical Technology and Surgical Assisting, the Surgical Assistant Association or the National Commission for Certification of Surgical Assistants, 2) have completed an appropriate training program while serving as a member of any branch of the armed forces of the United States, or 3) have practiced in the field of registration any time in the six months prior to July 1, 2014 (so long as they register with the Board by July 1, 2015)

The Board now proposes to promulgate a new regulation to implement Chapter 531. The proposed regulation varies from the text of the legislation only to require a current name and address for registrants and to set fees for initial registration, renewal of registration, late renewal of registration and returned checks. The Board proposes to charge $75 for initial registration, $70 for renewal (due in the birth month of the registrant in even numbered years), an additional $25 for individuals who renew after their renewal due date but within the next renewal cycle and $35 for any returned checks.

Individuals who worked at some point in the first six months of 2014 in their field and choose to register with the Board by July 1, 2015, and individuals who received appropriate training while serving in the military, will only incur initial registration costs of $75 plus very nominal time costs for providing required information to the Board. Individuals who qualify for registration because they hold certification from the National Board of Surgical Technology and Surgical Assisting, or one of the other certifying entities named in Chapter 531, will incur the same costs but may see a net savings at registration renewal. Chapter 531 does not require individuals to maintain certification in order to renew registration so individuals who do not need to stay certified as a requirement for their job may choose to just renew their registration with the Board of Medicine for $70 while choosing not to renew their certification at a cost of at least several hundred dollars.

Individuals who currently practice in these fields (or who may practice in these fields in the future) but do not qualify for registration on account of work done in the first six months of 2014 and have not been trained in the military will face much higher costs to become registered since meeting the criteria for certification with the National Board can cost many thousands of dollars. The likely result of this disparity in costs is that a smaller percentage of individuals practicing in these fields in the future will choose to become registered when compared to current practitioners in these fields.

Businesses and Entities Affected. Board staff reports that this proposed regulation will affect any individuals who currently work as surgical technologists and surgical assistants or who might work in these fields in the future. The Board estimates

that there are approximately 500 surgical assistants and 2,000 surgical technologists currently working in the Commonwealth.

Localities Particularly Affected. No localities will be particularly affected by these proposed regulatory changes.

Projected Impact on Employment. This regulatory action will likely have little impact on employment in the Commonwealth.

Effects on the Use and Value of Private Property. This regulatory action will likely have no effect on the use or value of private property in the Commonwealth.

Small Businesses: Costs and Other Effects. No affected small business is likely to incur costs on account of these proposed regulations.

Small Businesses: Alternative Method that Minimizes Adverse Impact. No affected small business is likely to incur costs on account of these proposed regulations.

Real Estate Development Costs. This regulatory action will likely have no effect on real estate development costs in the Commonwealth.

Legal Mandate.

General: The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007.04 of the Code of Virginia and Executive Order Number 17 (2014). Section 2.2-4007.04 requires that such economic impact analyses determine the public benefits and costs of the proposed amendments. Further the report should include but not be limited to:

- the projected number of businesses or other entities to whom the proposed regulation would apply,
- the identity of any localities and types of businesses or other entities particularly affected,
- the projected number of persons and employment positions to be affected,
- the projected costs to affected businesses or entities to implement or comply with the regulation, and
- the impact on the use and value of private property.

Small Businesses: If the proposed regulation will have an adverse effect on small businesses, § 2.2-4007.04 requires that such economic impact analyses include:

- an identification and estimate of the number of small businesses subject to the proposed regulation,
- the projected reporting, recordkeeping, and other administrative costs required for small businesses to comply with the proposed regulation, including the type of professional skills necessary for preparing required reports and other documents,
- a statement of the probable effect of the proposed regulation on affected small businesses, and
- a description of any less intrusive or less costly alternative methods of achieving the purpose of the proposed regulation.

Additionally, pursuant to § 2.2-4007.1, if there is a finding that a proposed regulation may have an adverse impact on small business, the Joint Commission on Administrative Rules (JCAR) is notified at the time the proposed regulation is submitted to the Virginia Register of Regulations for publication. This analysis shall represent DPB's best estimate for the purposes of public review and comment on the proposed regulation.

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

Summary:

Pursuant to Chapter 531 of the 2014 Acts of Assembly, the regulation establishes general provisions for the voluntary registration of surgical assistants and surgical technologists. The provisions include qualifications for registration, fees for application and renewal, and a requirement that a registrant maintain a current name and address with the Board of Medicine.

CHAPTER 160
REGULATIONS GOVERNING THE REGISTRATION OF SURGICAL ASSISTANTS AND SURGICAL TECHNOLOGISTS

18VAC85-160-10. Definitions.

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

"Board" means the Virginia Board of Medicine.

18VAC85-160-20. Public participation.

A separate regulation, 18VAC85-10, Public Participation Guidelines, provides for involvement of the public in the development of all regulations of the Virginia Board of Medicine.

18VAC85-160-30. Current name and address.

Each registrant shall furnish the board his current name and address of record. All notices required by law or by this chapter given by the board to any such registrant shall be validly given when mailed to the latest address of record provided or served to the registrant. Any change of name or address of record or public address, if different from the address of record, shall be furnished to the board within 30 days of such change.

18VAC85-160-40. Fees.

A. The following fees have been established by the board:

1. The fee for registration as a surgical assistant or surgical technologist shall be $75.

2. The fee for renewal of registration shall be $70. Renewals shall be due in the birth month of the registrant in each even-numbered year.

3. The additional fee for processing a late renewal application within one renewal cycle shall be $25.

4. The fee for a returned check shall be $35.

B. Unless otherwise provided, fees established by the board are not refundable.

18VAC85-160-50. Requirements for registration.

A. An applicant for registration shall submit a completed application and a fee as prescribed in 18VAC85-160-40 on forms provided by the board.

B. An applicant for registration as a surgical assistant shall provide evidence of:

1. A current credential as a surgical assistant or surgical first assistant issued by the National Board of Surgical Technology and Surgical Assisting, the National Surgical Assistant Association, or the National Commission for Certification of Surgical Assistants or their successors;

2. Successful completion of a surgical assistant training program during the applicant's service as a member of any branch of the armed forces of the United States; or

3. Practice as a surgical assistant at any time in the six months prior to July 1, 2014, provided the applicant registers with the board by July 1, 2015.

C. An applicant for registration as a surgical technologist shall provide evidence of:

1. A current credential as a certified surgical technologist from the National Board of Surgical Technology and Surgical Assisting or its successor; or

2. Successful completion of a surgical technologist training program during the applicant's service as a member of any branch of the armed forces of the United States; or

3. Practice as a surgical technologist at any time in the six months prior to July 1, 2014, provided the applicant registers with the board by July 1, 2015.

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

FORMS (18VAC85-160)

Application to Register as a Surgical Assistant or Surgical Technologist (rev. 12/2014)

VA.R. Doc. No. R15-4134; Filed December 10, 2014, 11:45 a.m.

BOARD OF NURSING

Fast-Track Regulation

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

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

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: January 28, 2015.

Effective Date: February 13, 2015.

Agency Contact: Jay P. Douglas, R.N., Executive Director, Board of Nursing, 9960 Mayland Drive, Suite 300, Richmond, VA 23233-1463, telephone (804) 367-4515, FAX (804) 527-4455, or email jay.douglas@dhp.virginia.gov.

Basis: Section 54.1-2400 of the Code of Virginia establishes the general powers and duties of health regulatory boards including the responsibility to promulgate regulations. Section 54.1-3408 L of the Code of Virginia provides for administration of drugs by an unlicensed person to a person receiving services from a program licensed by the Department of Behavioral Health and Developmental Services (DBHDS) via a gastrostomy tube provided the unlicensed person has successfully completed a training program approved by the Board of Nursing.

Purpose: The goal of the amendment to 18VAC90-21-30 is for the Board of Nursing to include a training module in gastrostomy tubes approved by DBHDS, which is designed to ensure that unlicensed persons have adequate competency to administer medications in a manner that protects the health and safety to persons receiving services in a DBHDS-approved program. The training prepared by DBHDS is an addition to the basic content of the curriculum for medication administration training program as authorized in § 54.1-3408 of the Code of Virginia.

Rationale for Using Fast-Track Process: An emergency regulation became effective on October 11, 2013, and a Notice of Intended Regulatory Action was published for the replacement of the emergency. During the 30-day comment period, there was no comment, and there have been no issues reported by providers or DBHDS with the regulation and training curriculum.

Substance: The key provision of the regulation is the inclusion of a requirement to complete the curriculum approved by the DBHDS for unlicensed persons to administer medication via a gastrostomy tube.

Issues: The primary advantage of the amendment to the public is better management of clients in facilities licensed by DBHDS who require a gastrostomy tube. There are no disadvantages to the public.

There are no advantages or disadvantages to the Commonwealth.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. Pursuant to Chapter 114 of the 2013 Acts of the Assembly, the Board of Nursing (Board) proposes to amend its regulations to require unlicensed individuals to complete training approved by the Board if they will be administering medication via a gastronomy tube to individuals who are being served by a program licensed by Department of Behavioral Health and Development Services (DBHDS). This proposed amendment will replace identical language promulgated under emergency regulation provisions that will expire April 11, 2015.

Result of Analysis. Benefits likely outweigh costs for this proposed regulatory change.

Estimated Economic Impact. Prior to 2013, only nurses, doctors and pharmacists had the authority to administer medication to patients through a gastronomy tube. This made it prohibitively expensive to move affected intellectually disabled individuals from the state's training centers (where nurses were available to administer such medication) to community-based group homes (which usually do not employ nurses). In 2013, the General Assembly passed legislation that addressed this issue by allowing unlicensed individuals to administer medication through clients' gastronomy tubes after they successfully completed a training course approved by the Board.

Board staff reports that the approved training course is six hours long. Staff at DBHDS reports that roughly 400 individuals who require medication administration through gastronomy tubes are currently being cared for in group homes licensed by the Department. Several hundred workers at these homes have completed or will complete training approved by the Board under these regulations. DBHDS staff further estimates that the six hour training course costs several hundred dollars and that group home staff members typically earn an hourly wage between $10 and $12. Using these estimates, owners of group homes who wish to serve clients who would need medication administered through their gastronomy tubes will likely incur costs that include the training course fee as well as wage costs of between $60 and $72 for each worker who completes training. These costs are likely much lower than hiring a nurse to administer these medications.

Businesses and Entities Affected. Staff for DBHDS estimates that several hundred group homes, as well as all intellectually disabled individuals who require medication administration through gastronomy tubes, will be affected by these regulations.

Localities Particularly Affected. No locality will be particularly affected by this proposed regulatory action.

Projected Impact on Employment. Because this regulatory change likely allows a greater number of intellectually disabled individuals to be served by group homes, employment in such homes is likely to slightly increase.

Effects on the Use and Value of Private Property. To the extent that this regulatory change allows a greater number of intellectually disabled individuals to live in group homes, the revenue of such homes is likely to increase.

Small Businesses: Costs and Other Effects. Affected small businesses will likely incur costs for training fees and wages paid to workers completing training; these costs are likely much lower than costs would be if affected small businesses had to hire nurses to administer medication through gastronomy tubes.

Small Businesses: Alternative Method that Minimizes Adverse Impact. Affected small businesses will likely incur costs for training fees and wages paid to workers completing training; these costs are likely much lower than costs would be if affected small businesses had to hire nurses to administer medication through gastronomy tubes.

Real Estate Development Costs. This proposed regulatory change will likely have no effect on real estate development costs in the Commonwealth.

Legal Mandate.

General: The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007.04 of the Code of Virginia and Executive Order Number 14 (2010). Section 2.2-4007.04 requires that such economic impact analyses determine the public benefits and costs of the proposed amendments. Further the report should include but not be limited to:

- the projected number of businesses or other entities to whom the proposed regulation would apply,
- the identity of any localities and types of businesses or other entities particularly affected,
- the projected number of persons and employment positions to be affected,
- the projected costs to affected businesses or entities to implement or comply with the regulation, and
- the impact on the use and value of private property.

Small Businesses: If the proposed regulation will have an adverse effect on small businesses, § 2.2-4007.04 requires that such economic impact analyses include:

- an identification and estimate of the number of small businesses subject to the proposed regulation,
- the projected reporting, recordkeeping, and other administrative costs required for small businesses to comply with the proposed regulation, including the type of professional skills necessary for preparing required reports and other documents,
- a statement of the probable effect of the proposed regulation on affected small businesses, and

• a description of any less intrusive or less costly alternative methods of achieving the purpose of the proposed regulation.

Additionally, pursuant to § 2.2-4007.1, if there is a finding that a proposed regulation may have an adverse impact on small business, the Joint Commission on Administrative Rules (JCAR) is notified at the time the proposed regulation is submitted to the Virginia Register of Regulations for publication. This analysis shall represent DPB's best estimate for the purposes of public review and comment on the proposed regulation.

Agency's Response to Economic Impact Analysis: The Board of Nursing concurs with the analysis of the Department of Planning and Budget on proposed amended regulations for 18VAC90-20.

Summary:

The amendments require unlicensed individuals to complete the curriculum approved by the Department of Behavioral Health and Developmental Services if they will be administering medication via a gastronomy tube to individuals who are being served by a program licensed by Department of Behavioral Health and Developmental Services.

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

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

1. Preparing for safe administration of medications to clients in specific settings by:

a. Demonstrating an understanding of the client's rights regarding medications, treatment decisions, and confidentiality.

b. Recognizing emergencies and other health-threatening conditions and responding accordingly.

c. Identifying medication terminology and abbreviations.

2. Maintaining aseptic conditions by:

a. Implementing universal precautions.

b. Insuring cleanliness and disinfection.

c. Disposing of infectious or hazardous waste.

3. Facilitating client self-administration or assisting with medication administration by:

a. Reviewing administration records and prescriber's orders.

b. Facilitating client's awareness of the purpose and effects of medication.

c. Assisting the client to interpret prescription labels.

d. Observing the five rights of medication administration and security requirements appropriate to the setting.

e. Following proper procedure for preparing medications.

f. Measuring and recording vital signs to assist the client in making medication administration decisions.

g. Assisting the client to administer oral medications.

h. Assisting the client with administration of prepared instillations and treatments of:

(1) Eye drops and ointments.

(2) Ear drops.

(3) Nasal drops and sprays.

(4) Topical preparations.

(5) Compresses and dressings.

(6) Vaginal and rectal products.

(7) Soaks and sitz baths.

(8) Inhalation therapy.

(9) Oral hygiene products.

i. Reporting and recording the client's refusal to take medication.

j. Documenting medication administration.

k. Documenting and reporting medication errors.

l. Maintaining client records according to facility policy.

m. Sharing information with other staff orally and by using documents.

n. Storing and securing medications.

o. Maintaining an inventory of medications.

p. Disposing of medications.

4. Facilitating client self-administration or assisting with the administration of insulin. Instruction and practice in the administration of insulin shall be included only in those settings where required by client needs and shall include:

a. Cause and treatment of diabetes.

b. The side effects of insulin.

c. Preparation and administration of insulin.

d. Signs of severe hypoglycemia and administration of glucagon.

5. Facilitating client self-administration or assisting with the administration of auto-injectable epinephrine pursuant to an order issued by the prescriber for a specific client in a facility licensed by the Department of Behavioral Health and Developmental Services under the provisions of subsection D of § 54.1-3408 of the Code of Virginia.

B. Pursuant to subsection L of § 54.1-3408 of the Code of Virginia, the board requires successful completion of the curriculum approved by the Department of Behavioral Health and Developmental Services (DBHDS) for unlicensed persons to administer medication via a gastrostomy tube to a person receiving services from a program licensed by the DBHDS.

VA.R. Doc. No. R14-3733; Filed December 10, 2014, 11:45 a.m.

EXECUTIVE ORDER NUMBER 35 (2014)

CONTINUATION OF THE VIRGINIA COASTAL ZONE MANAGEMENT PROGRAM

Important of the Initiative

The Virginia Coastal Zone Management Program's ("Program") mission is to create more vital and sustainable coastal communities and ecosystems. The Department of Environmental Quality will serve as the lead agency for this networked program and will be responsible for allocation and assignment of all federal funds received for the Virginia Coastal Zone Management Program Implementation Grant.

By virtue of the authority vested in me as Governor under Article V of the Constitution of Virginia and under the laws of the Commonwealth, including but not limited to Sections 2.2-103 and 2.2-104 of the Code of Virginia, and subject to my continuing and ultimate authority and responsibility to act in such matters, I hereby continue the Virginia Coastal Zone Management Program.

POLICY GOALS

State agencies having responsibility for the Commonwealth's coastal resources shall promote the Coastal Zone Management Program consistent with the following goals:

Coastal and Ocean Resource Protection

Goal l: To protect and restore coastal and ocean resources, habitats, and species of the Commonwealth. These include, but are not limited to, wetlands, subaqueous lands and vegetation, beaches, sand dune systems, barrier islands, underwater or maritime cultural resources, riparian forested buffers, and endangered or threatened species.

Goal 2: To restore and maintain the quality of all coastal and ocean waters for human and ecosystem health through protection from adverse effects of excess nutrients, toxics, pathogens, and sedimentation.

Goal 3: To protect air quality.

Goal 4: To reduce or prevent losses of coastal habitat, life, and property caused by shoreline erosion, storms, relative sea level rise, and other coastal hazards in a manner that balances environmental and economic considerations.

Coastal and Ocean Resource Sustainable Use

Goal 5: To provide for sustainable wild fisheries and aquaculture.

Goal 6: To promote sustainable ecotourism and to increase and improve public access to coastal waters and shorefront lands compatible with resource protection goals.

Goal 7: To promote renewable energy production and provide for appropriate extraction of energy and mineral resources consistent with proper environmental practices.

Coastal and Ocean Management Coordination

Goal 8: To ensure sustainable development on coastal lands and support access for water-dependent development through effective coordination of governmental planning processes.

Goal 9: To avoid and minimize coastal and ocean resource use conflicts through research, planning, and a forum for coordination and facilitation among local, regional, state, and federal government agencies, interest groups, and citizens.

Goal 10: To promote informed decision-making by maximizing the availability of up-to-date educational information, technical advice, and scientific data including the use of new tools such as marine spatial planning.

IMPLEMENTATION AND ENFORCEMENT

The following agencies, in cooperation with local governments, as appropriate, shall have primary responsibility for implementing the enforceable policies of Virginia's Coastal Zone Management Program as approved by the National Oceanic and Atmospheric Administration:

Responsible Agency and Enforceable Policies

Department of Environmental Quality (DEQ)

- Point source water pollution management and nontidal wetlands management
- Air pollution
- Nonpoint source pollution management
- Coastal lands management

Marine Resources Commission (MRC)

- Primary sand dunes management
- Tidal wetlands management
- Subaqueous lands management
- Fisheries management (shared with DGIF)

Department of Game and Inland Fisheries (DGIF)

- Fisheries management (shared with MRC)

Department of Health

- Shoreline sanitation

The following agencies are responsible for assisting with the program:

- Department of Conservation & Recreation
- Department of Agriculture and Consumer Services
- Department of Forestry
- Department of Historic Resources
- Department of Mines, Minerals & Energy

Department of Transportation

Virginia Economic Development Partnership

Virginia Institute of Marine Science

Virginia Department of Emergency Management

In addition, other agencies that conduct activities that may affect coastal resources shall conduct such activities in a manner consistent with and supportive of Virginia's Coastal Zone Management Program. For purposes of this Program, the Coastal Area shall mean Tidewater Virginia as defined in Section 28.2-100 of the Code of Virginia, inclusive of all tidal waters out to the three nautical mile Territorial Sea Boundary.

The Director of the Department of Environmental Quality shall monitor all state actions that affect coastal resources. When, in the judgment of the DEQ Director, a state agency, regulatory board, or commission is about to act in a manner that appears to be inconsistent with the Program or has established a pattern of actions that appears to be inconsistent with the Program, the Director shall discuss the situation with the head of such agency, board, or commission to determine if a consistency problem exists.

If, after discussion, the head of such agency, board, or commission and the Director of DEQ are in disagreement about the existence of a consistency problem, the Director will inform the Secretary of Natural Resources of the disagreement. The Secretary shall then determine if a state interagency consistency problem exists.

If the head of such agency, board, or commission and the Director of DEQ agree that a consistency problem exists, they shall attempt to resolve the problem. If they cannot resolve the problem, the Director shall advise the Secretary that an unresolved interagency consistency problem exists.

Upon notification of the existence of an unresolved consistency problem, the Secretary shall review the problem, determine how it should best be resolved, and affect such resolution within the Secretariat of Natural Resources or consult with other Cabinet Secretaries to resolve a consistency problem with agencies, boards, or commissions not within the Secretariat of Natural Resources. If unable to resolve the problem, the Secretary shall report to the Governor and recommend appropriate action. The Governor shall have the ultimate responsibility for resolving any interagency consistency problem that cannot be resolved by the Secretary of Natural Resources.

Any person having authority to resolve consistency problems under the terms of this Executive Order shall resolve those problems in a manner that furthers the goals and objectives of the Program as set forth above and in accordance with existing state law, regulations, and administrative procedures.

Effective Date of the Executive Order

This Executive Order rescinds Executive Order No. 18 (2010), issued by Governor Robert F. McDonnell. This Executive Order shall be effective upon its signing and shall remain in full force and effect until June 30, 2018, unless amended or rescinded by further executive order.

Given under my hand and under the Seal of the Commonwealth of Virginia on this 2nd day of December, 2014.

/s/ Terence R. McAuliffe
Governor

EXECUTIVE ORDER NUMBER 36 (2014)

Continuing Qualified Energy Conservation Bonds

Importance of the Issue

The Commonwealth of Virginia endeavors to facilitate the use of all available tools for projects that reduce energy consumption and encourage energy efficiency and conservation in the public and private sectors. Federal Qualified Energy Conservation Bonds ("QECBs") are significant tools that can be used by the state and local governments, as well as the private sector, to lower the cost of financing energy efficiency, conservation, and renewable generation projects. QECBs are tax credits or direct pay bonds that may be issued by states, political subdivisions, and entities empowered to issue bonds on behalf of such entities, including eligible issuers in conduit financing issues for one or more qualified conservation purpose(s).

By virtue of the authority vested in me as Governor under Article V of the Constitution of Virginia and Section 2.2-103 of the Code of Virginia, and subject to my continuing and ultimate authority and responsibility to act in such matters, I hereby continue allocating the Original Locality Suballocations, minus the amounts that have been previously utilized.

Initiative

The Director of the Division of Energy of the Department of Mines, Minerals and Energy will act as the QECB Allocation Director, and work in conjunction with the Executive Director of the Virginia Small Business Financing Authority. The QECB Allocation Director will establish a process to develop a green community program and to consider such programs, with other eligible QECB uses and programs, in determining the allocation and reallocation of any unallocated amounts or waived amounts as described to applicants.

The QECB Allocation Director is further directed to issue a Request for Proposal (RFP) to select a firm or firms for the administration of the green community program within 60 days of issuance of this Executive Order. No bonds issued under allocations provided by this Executive Order will be

state-supported debt without prior approval of the General Assembly.

The Originally Awarded Localities will have nine months from the issuance of this Executive Order to provide the QECB Allocation Director with written notice of intent to utilize their Original Locality Suballocation and provide documentation acceptable to the QECB Allocation Director identifying a specific project or projects for which the Original Locality Suballocation will be used. Further, they will have twelve months from the issuance of this Executive Order to utilize their Original Locality Suballocation and provide documentation to the QECB Allocation Director evidencing such use. If no notice is given or no use evidenced within either of the prescribed time periods, the unused Original Locality Suballocation will be deemed waived and returned to the QECB Allocation Director for reallocation to other qualifying projects.

Originally Awarded Localities may also waive their Original Locality Suballocation at any time within the twelve month period after the issuance of this Executive Order. The QECB Allocation Director is directed to establish, within 120 days of the issuance of this Executive Order, policies and procedures for the reallocation of any waived Original Locality Suballocation or subsequent allocations to eligible QECB uses and programs.

Suballocation

The QECB Allocation from the federal government to Virginia is $80,600,000. The Original Locality Suballocations, minus the amounts used as of the issuance of this Executive Order, are as follows:

Originally Awarded Locality	Population	Percentage	Original Suballocation	Used	Remaining Suballocation
Fairfax County	1,004,151	13.04%	$10,512,656	--	$10,512,656
Virginia Beach City	435,004	5.65%	$4,554,143	--	$4,554,143
Prince William County	359,588	4.67%	$3,764,598	--	$3,764,598
Chesterfield County	299,022	3.88%	$3,130,521	--	$3,130,521
Henrico County	289,460	3.76%	$3,030,414	--	$3,030,414
Loudoun County	277,346	3.60%	$2,903,590	--	$2,903,590
Norfolk City	235,982	3.07%	$2,470,542	$2,470,542	$0
Chesapeake City	218,830	2.84%	$2,290,975	--	$2,290,975
Arlington County	203,909	2.65%	$2,134,764	--	$2,134,764
Richmond City	199,991	2.60%	$2,093,745	--	$2,093,745
Newport News City	180,810	2.35%	$1,892,936	--	$1,892,936
Hampton City	146,466	1.90%	$1,533,382	--	$1,533,382
Alexandria City	139,848	1.82%	$1,464,095	--	$1,464,095
Stafford County	120,621	1.57%	$1,262,805	--	$1,262,805

Spotsylvania County	118,887	1.54%	$1,244,652	$1,244,652	$0
Portsmouth City	101,931	1.32%	$1,067,136	--	$1,067,136
Total Locality Suballocation			$45,350,954	$3,715,194	$41,635,760

1. Each Locality utilizing a suballocation of QECBs shall ensure compliance with the 70% Use Requirement or the Green Community Program Use Requirement, pursuant to Section 54D(e)(4) of the Internal Revenue Code, and upon issuance of any QECBs will provide a copy of IRS form 8038 to the QECB Allocation Director.

2. The Determination of compliance with the procedures and requirements set forth in this Executive Order or in the additional guidance, including any filings to be made and the timing and substance, will be subject to the sole discretion of the Allocation Director.

This Executive Order shall be effective upon its signing and shall remain in full force and effect until December 31, 2017, unless amended or rescinded by further executive order.

Given under my hand and under the Seal of the Commonwealth of Virginia this 10th day of December, 2014.

/s/ Terence R. McAuliffe
Governor

DEPARTMENT OF HEALTH

January 2015 Drinking Water State Revolving Funds

The Virginia Department of Health (VDH) is pleased to announce several opportunities for funding drinking water infrastructure. All applications may be submitted year round; however, VDH will conduct one round of evaluations for requests submitted by the deadlines listed below. Applications postmarked/received after the due date will be considered for funding in the following round. Funding is made possible by our Drinking Water State Revolving Fund (DWSRF) Program and the Water Supply Assistance Grant Fund (WSAG) Program (if funds are available). The FY 2016 DWSRF Intended Use Plan will be developed using input on these issues:

1. Public Comments and Set-Aside Suggestions Invited (Submission deadline April 1, 2015). To identify ways to improve our program, VDH seeks meaningful input from the public, the waterworks industry, or other interested party. Anyone may make comments or recommendations to support or revise the program. Anyone has the opportunity to suggest new or continuing set-aside (nonconstruction) activities. Set-aside funds help VDH assist waterworks owners to prepare for future drinking water challenges and assure the sustainability of safe drinking water. VDH will consider all comments and suggestions submitted by April 1, 2015.

2. Construction and Refinance Fund Requests (Application deadline April 1, 2015). Owners of community waterworks and nonprofit noncommunity waterworks are eligible to apply for construction funds. VDH makes selections based on criteria described in the DWSRF Program Design Manual, such as existing public health problems, noncompliance, affordability, regionalization, and the availability of matching funds. Readiness to proceed with construction is a key element. A preliminary engineering report, or waiver, must be submitted as required by VDH. An instruction packet and construction project schedule are included. VDH anticipates a funding level of $24 million.

3. 1452(k) Source Water Protection Initiatives (Application deadline April 1, 2015). This provision allows VDH to loan money for activities to protect important drinking water resources. Loan funds are available to: (1) community and nonprofit noncommunity waterworks to acquire land/conservation easements and (2) community waterworks, only to establish local voluntary incentive-based protection measures.

4. Planning and Design Grants (Application deadlines April 1, 2015 and Sept. 1, 2015). Private and public owners of community waterworks are eligible to apply for these grant funds. Grants can be up to $50,000 per project for small, financially stressed, community waterworks serving fewer than 10,000 persons. Eligible projects may include preliminary engineering planning, design of plans and specifications, performance of source water quality and quantity studies, drilling test wells to determine source feasibility, or other similar technical assistance projects. These funds could assist the waterworks owner in future submittals for construction funds. There are two application deadlines for planning grant application submittals: April 1, 2015, and September 1, 2015. VDH intends to conduct two rounds of evaluations and offers.

The VDH's DWSRF Program Design Manual describes the features of the above opportunities for funding. After receiving public input, VDH will develop a draft intended use plan (IUP) for public review and comment. When developed the draft IUP will describe specific details for use of the funds. A public meeting is planned and written comments will be accepted before submittal of a final version to the USEPA for approval.

Applications, set-aside suggestion forms, Program Design Manuals and information materials are available on our website: http://www.vdh.virginia.gov/odw/financial/dwfundingprogramdetails.htm. This information can also be obtained from and comments can be directed to Steven Pellei, PE, FCAP Director, by calling (804) 864-7500, faxing (804) 864-7521, or writing to Virginia Department of Health, Office of Drinking Water, 109 Governor Street, 6th Floor, Richmond, VA 23219.

VIRGINIA LOTTERY

Director's Orders

The following Director's Orders of the Virginia Lottery were filed with the Virginia Registrar of Regulations on December 8, 2014. The orders may be viewed at the Virginia Lottery, 900 East Main Street, Richmond, Virginia, or at the office of the Registrar of Regulations, 201 North 9th Street, 2nd Floor, Richmond, Virginia.

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

Virginia Lottery's "Social Media Sweepstakes/Contest" Final Rules for Operation (effective October 31, 2014)

Director's Order Number One Hundred Fifty (14)

Virginia's Instant Game Lottery 1523 "$250,000 Jackpot Doubler" Final Rules for Game Operation (effective November 12, 2014)

Director's Order Number One Hundred Fifty-One (14)

Virginia's Instant Game Lottery 1517 "Diamonds & Gold" Final Rules for Game Operation (effective November 12, 2014)

Director's Order Number One Hundred Fifty-Three (14)

Virginia's Instant Game Lottery 1525 "5X The Money" Final Rules for Game Operation (effective December 2, 2014)

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

Virginia Lottery's "Mega Power Throw Back Promotion" Final Rules for Operation (This Director's Order becomes effective on Tuesday, January 6, 2015, and shall remain in full force and effect unless amended or rescinded by further Director's Order.)

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

Virginia Lottery's Scratcher Throw Back Promotion Final Rules for Operation (This Director's Order becomes effective on Tuesday, January 6, 2015, and shall remain in full force and effect unless amended or rescinded by further Director's Order)

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

Virginia's Computer-Generated Game "Decades Of Dollars" Final Rules for Game Operation (This Director's Order becomes effective on November 6, 2014, rescinds and replaces Director's Order One Hundred Forty-Four (14), and shall remain in full force and effect unless amended or rescinded by further Director's Order)

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

Lift Program Retailer Advertising Virginia Lottery Retailer Incentive Program Requirements (This Director's Order becomes effective on December 5, 2014, and shall remain in full force and effect until ninety (90) days after the conclusion of the Incentive Program unless otherwise extended by the Director)

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

Virginia's Instant Game Lottery 1521 "Cash King" Final Rules for Game Operation (effective December 2, 2014)

Director's Order Number One Hundred Sixty (14)

Virginia's Instant Game Lottery 1524 "Joker's Jackpot" Final Rules for Game Operation (effective December 7, 2014)

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

Virginia's Computer-Generated Game Lottery "Fastplay Cold Hard Cash" Final Rules for Game Operation (This Director's Order becomes effective on Monday, December 8, 2014, and shall remain in full force and effect unless amended or rescinded by further Director's Order)

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

Virginia's Computer-Generated Game Lottery "Fastplay Crossword" Final Rules for Game Operation (This Director's Order becomes effective on Monday, December 8, 2014, and shall remain in full force and effect unless amended or rescinded by further Director's Order)

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

Virginia's Computer-Generated Game Lottery "Fastplay Fast $50's Gold Bar Doubler" Final Rules for Game Operation (This Director's Order becomes effective on Monday, December 8, 2014, and shall remain in full force and effect unless amended or rescinded by further Director's Order)

DEPARTMENT OF STATE POLICE

Small Business Impact Review - Report of Findings

Pursuant to § 2.2-4007.1 of the Code of Virginia, the Department of State Police conducted a small business impact review of **19VAC30-11**, **Public Participation Guidelines,** and determined that this regulation should be retained in its current form. The Department of State Police is publishing its report of findings dated December 3, 2014, to support this decision in accordance with § 2.2-4007.1 F of the Code of Virginia.

In determining economic impact on small business the agency determined that (1) the statutory authority both authorizes and necessitates the continued need for the regulation; (2) no complaints or comments were received concerning the regulation from the public; 3) the regulation is not complex and provides a basic framework for administering the program; 4) the regulation does not overlap, duplicate, or conflict with federal or state law or regulation; and 5) technological, economic, or other changes in the area affected by the regulation have not impacted the need or form of the regulation. The regulation intended to protect the citizens of the Commonwealth is consistent with the stated objectives of applicable law and has little or no economic impact on small businesses. The regulation shall therefore be retained in its current form.

Contact Information: Major Tracy Russillo, BASS Deputy Director, P.O. Box 27472, Richmond, VA 23261-7472, telephone (804) 674-2066, FAX (804) 674-2936, or email bassdiri@vsp.virginia.gov.

Small Business Impact Review - Report of Findings

Pursuant to § 2.2-4007.1 of the Code of Virginia, the Department of State Police conducted a small business impact review of **19VAC30-40, Standards and Specifications for the Stickers or Decals Used by Cities, Counties and Towns in Lieu of License Plates,** and determined that this regulation should be retained in its current form. The Department of State Police is publishing its report of findings dated December 3, 2014, to support this decision in accordance with § 2.2-4007.1 F of the Code of Virginia.

In determining economic impact on small business the agency determined that (1) the statutory authority both authorizes and necessitates the continued need for the regulation; (2) no complaints or comments were received concerning the regulation from the public; 3) the regulation is not complex and provides a basic framework for administering the program; 4) the regulation does not overlap, duplicate, or conflict with federal or state law or regulation; and 5) technological, economic, or other changes in the area affected

by the regulation have not impacted the need or form of the regulation. The regulation intended to protect the citizens of the Commonwealth is consistent with the stated objectives of applicable law and has little or no economic impact on small businesses. The regulation shall therefore be retained in its current form.

Contact Information: Captain F. Daniel Glick, Safety Officer, P.O. Box 27472, Richmond, VA 23261-7472, telephone (804) 674-6774, FAX (804) 674-2916, or email safety@vsp.virginia.gov.

Small Business Impact Review - Report of Findings

Pursuant to § 2.2-4007.1 of the Code of Virginia, the Department of State Police conducted a small business impact review of **19VAC30-80, Regulations Relating to Specifications of the Description to be Obtained by Pawnbrokers of Persons Pawning or Pledging Goods,** and determined that this regulation should be retained in its current form. The Department of State Police is publishing its report of findings dated December 3, 2014, to support this decision in accordance with § 2.2-4007.1 F of the Code of Virginia.

In determining economic impact on small business the agency determined that (1) the statutory authority both authorizes and necessitates the continued need for the regulation; (2) no complaints or comments were received concerning the regulation from the public; 3) the regulation is not complex and provides a basic framework for administering the program; 4) the regulation does not overlap, duplicate, or conflict with federal or state law or regulation; and 5) technological, economic, or other changes in the area affected by the regulation have not impacted the need or form of the regulation. The regulation intended to protect the citizens of the Commonwealth is consistent with the stated objectives of applicable law and has little or no economic impact on small businesses. The requirement to report the items pawned is statutory in nature, so the regulations do not impose any additional duty on small business. The regulation shall therefore be retained in its current form.

Contact Information: Captain Thomas Turner, CJIS Officer, P.O. Box 27472, Richmond, VA 23261-7472, telephone (804) 674-2147, FAX (804) 674-2918, or email cjis@vsp.virginia.gov.

Small Business Impact Review - Report of Findings

Pursuant to § 2.2-4007.1 of the Code of Virginia, the Department of State Police conducted a small business impact review of **19VAC30-110, Regulations Governing the Creation of a Criminal Firearms Clearinghouse,** and determined that this regulation should be retained in its current form. The Department of State Police is publishing its report of findings dated December 2, 2014, to support this decision in accordance with § 2.2-4007.1 F of the Code of Virginia.

In determining economic impact on small business the agency determined that (1) the statutory authority both authorizes and necessitates the continued need for the regulation; (2) no complaints or comments were received concerning the regulation from the public; 3) the regulation is not complex and provides a basic framework for administering the program; 4) the regulation does not overlap, duplicate, or conflict with federal or state law or regulation; and 5) technological, economic, or other changes in the area affected by the regulation have not impacted the need or form of the regulation. The regulation intended to protect the citizens of the Commonwealth is consistent with the stated objectives of applicable law and has little or no economic impact on small businesses. The regulation shall therefore be retained in its current form.

Contact Information: Captain Thomas Turner, CJIS Officer, P.O. Box 27472, Richmond, VA 23261-7472, telephone (804) 674-2147, FAX (804) 674-2918, or email cjis@vsp.virginia.gov.

Small Business Impact Review - Report of Findings

Pursuant to § 2.2-4007.1 of the Code of Virginia, the Department of State Police conducted a small business impact review of **19VAC30-140, Regulations Relating to Standards and Specifications for Back-Up Audible Alarm Signals,** and determined that this regulation should be retained in its current form. The Department of State Police is publishing its report of findings dated December 5, 2014, to support this decision in accordance with § 2.2-4007.1 F of the Code of Virginia.

In determining economic impact on small business the agency determined that (1) the statutory authority both authorizes and necessitates the continued need for the regulation; (2) no complaints or comments were received concerning the regulation from the public; 3) the regulation is not complex and provides a basic framework for administering the program; 4) the regulation does not overlap, duplicate, or conflict with federal or state law or regulation; and 5) technological, economic, or other changes in the area affected by the regulation have not impacted the need or form of the regulation. The regulation intended to protect the citizens of the Commonwealth is consistent with the stated objectives of applicable law and has little or no economic impact on small businesses. The requirement to have these signals is statutory in nature, so the regulations do not impose any additional duty on small business. The regulation shall therefore be retained in its current form.

Contact Information: Captain F. Daniel Glick, Safety Officer, P.O. Box 27472, Richmond, VA 23261-7472, telephone (804) 674-6774, FAX (804) 674-2916, or email safety@vsp.virginia.gov.

Small Business Impact Review - Report of Findings

Pursuant to § 2.2-4007.1 of the Code of Virginia, the Department of State Police conducted a small business impact review of **19VAC30-170, Regulations Governing the Operation and Maintenance of the Sex Offender and Crimes Against Minors Registry,** and determined that this regulation should be retained in its current form. The Department of State Police is publishing its report of findings dated December 2, 2014, to support this decision in accordance with § 2.2-4007.1 F of the Code of Virginia.

In determining economic impact on small business the agency determined that (1) the statutory authority both authorizes and necessitates the continued need for the regulation; (2) no complaints or comments were received concerning the regulation from the public; 3) the regulation is not complex and provides a basic framework for administering the program; 4) the regulation does not overlap, duplicate, or conflict with federal or state law or regulation; and 5) technological, economic, or other changes in the area affected by the regulation have not impacted the need or form of the regulation. The regulation intended to protect the citizens of the Commonwealth is consistent with the stated objectives of applicable law and has little or no economic impact on small businesses. The regulation shall therefore be retained in its current form.

Contact Information: Captain Thomas Turner, CJIS Officer, P.O. Box 27472, Richmond, VA 23261-7472, telephone (804) 674-2147, FAX (804) 674-2918, or email cjis@vsp.virginia.gov.

Small Business Impact Review - Report of Findings

Pursuant to § 2.2-4007.1 of the Code of Virginia, the Department of State Police conducted a small business impact review of **19VAC30-180, Regulations Governing the Establishment and Maintenance of the Witness Protection Program,** and determined that this regulation should be retained in its current form. The Department of State Police is publishing its report of findings dated December 2, 2014, to support this decision in accordance with § 2.2-4007.1 F of the Code of Virginia.

In determining economic impact on small business the agency determined that (1) the statutory authority both authorizes and necessitates the continued need for the regulation; (2) no complaints or comments were received concerning the regulation from the public; 3) the regulation is not complex and provides a basic framework for administering the program; 4) the regulation does not overlap, duplicate, or conflict with federal or state law or regulation; and 5) technological, economic, or other changes in the area affected by the regulation have not impacted the need or form of the regulation. The regulation intended to protect the victims of crime is consistent with the stated objectives of applicable law and has little or no economic impact on small businesses. The regulation shall therefore be retained in its current form.

Contact Information: Lieutenant Verlan Hall, BCI Staff Lieutenant, P.O. Box 27472, Richmond, VA 23261-7472, telephone (804) 674-2108, FAX (804) 674-2936, or email vspbci@vsp.virginia.gov.

Small Business Impact Review - Report of Findings

Pursuant to § 2.2-4007.1 of the Code of Virginia, the Department of State Police conducted a small business impact review of **19VAC30-200, Approved Helmets for All-Terrain Vehicles and Mopeds,** and determined that this regulation should be retained in its current form. The Department of State Police is publishing its report of findings dated December 5, 2014, to support this decision in accordance with § 2.2-4007.1 F of the Code of Virginia.

In determining economic impact on small business the agency determined that (1) the statutory authority both authorizes and necessitates the continued need for the regulation; (2) no complaints or comments were received concerning the regulation from the public; 3) the regulation is not complex and provides a basic framework for administering the program; 4) the regulation does not overlap, duplicate, or conflict with federal or state law or regulation; and 5) technological, economic, or other changes in the area affected by the regulation have not impacted the need or form of the regulation. The regulation intended to protect the citizens of the Commonwealth is consistent with the stated objectives of applicable law and has little or no economic impact on small businesses. The requirement to have approved helmets is statutory in nature, so the regulations, which adopt nationally accepted standards, do not impose any additional duty on small business. The regulation shall therefore be retained in its current form.

Contact Information: Captain F. Daniel Glick, Safety Officer, P.O. Box 27472, Richmond, VA 23261-7472, telephone (804) 674-6774, FAX (804) 674-2916, or email safety@vsp.virginia.gov.

VIRGINIA CODE COMMISSION

Notice to State Agencies

Contact Information: *Mailing Address:* Virginia Code Commission, General Assembly Building, 201 North 9th Street, 2nd Floor, Richmond, VA 23219; *Telephone:* Voice (804) 786-3591; FAX (804) 692-0625; *Email:* varegs@dls.virginia.gov.

Meeting Notices: Section 2.2-3707 C of the Code of Virginia requires state agencies to post meeting notices on their websites and on the Commonwealth Calendar at http://www.virginia.gov/connect/commonwealth-calendar.

Cumulative Table of Virginia Administrative Code Sections Adopted, Amended, or Repealed: A table listing

regulation sections that have been amended, added, or repealed in the *Virginia Register of Regulations* since the regulations were originally published or last supplemented in the print version of the Virginia Administrative Code is available at http://register.dls.virginia.gov/documents/cumultab.pdf.

Filing Material for Publication in the *Virginia Register of Regulations*: Agencies use the Regulation Information System (RIS) to file regulations and related items for publication in the *Virginia Register of Regulations*. The Registrar's office works closely with the Department of Planning and Budget (DPB) to coordinate the system with the Virginia Regulatory Town Hall. RIS and Town Hall complement and enhance one another by sharing pertinent regulatory information.

ERRATA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Title of Regulation: **12VAC30-120. Waivered Services.**

Publication: 31:5 VA.R. 303-311 November 3, 2014.

Correction to Effective Dates:

Replace "April 1, 2016" with "April 30, 2016"

VA.R. Doc. No. R15-3839; Filed December 10, 2014, 5:28 p.m.