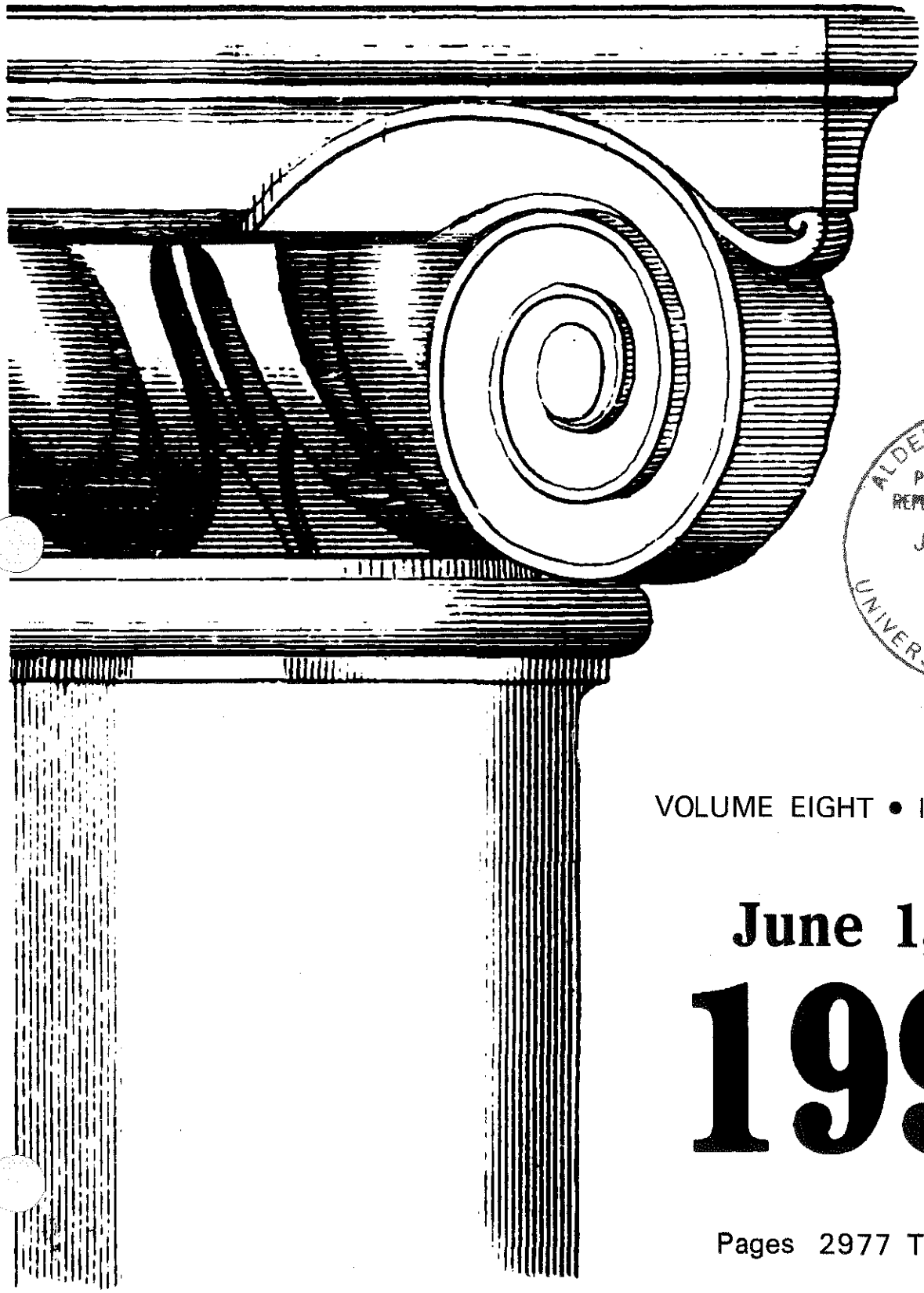
THE VIRGINIA REGISTER

OF REGULATIONS



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VIRGINIA REGISTER

The *Virginia Register* is an official state publication issued every other week throughout the year. Indexes are published quarterly, and the last index of the year is cumulative.

The *Virginia Register* has several functions. The full text of all regulations, both as proposed and as finally adopted or changed by amendment are required by law to be published in the *Virginia Register of Regulations.*

In addition, the *Virginia Register* is a source of other information about state government, including all Emergency Regulations issued by the Governor, and Executive Orders, the Virginia Tax Bulletin issued periodically by the Department of Taxation, and notices of all public hearings and open meetings of state agencies.

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 proposed action; a basis, purpose, impact and summary statement; a notice giving the public an opportunity to comment on the proposal, and the text of the proposed regulations.

Under the provisions of the Administrative Process Act, the Registrar has the right to publish a summary, rather than the full text, of a regulation which is considered to be too lengthy. In such case, the full text of the regulation will be available for public inspection at the office of the Registrar and at the office of the promulgating agency.

Following publication of the proposal in the *Virginia Register,* sixty days must elapse before the agency may take action on the proposal.

During this time, the Governor and the General Assembly will review the proposed regulations. The Governor will transmit his comments on the regulations to the Registrar and the agency and such comments will be published in the *Virginia Register.*

Upon receipt of the Governor's comment on a proposed regulation, the agency (i) may adopt the proposed regulation, if the Governor has no objection to the regulation; (ii) may modify and adopt the proposed regulation after considering and incorporating the Governor's suggestions, or (iii) may adopt the regulation without changes despite the Governor's recommendations for change.

The appropriate standing committee of each branch of the General Assembly may meet during the promulgation or final adoption process and file an objection with the *Virginia Registrar* and the promulgating agency. The objection will be published in the *Virginia Register.* Within twenty-one days after receipt by the agency of a legislative objection, the agency shall file a response with the Registrar, the objecting legislative Committee, and the Governor

When final action is taken, the promulgating agency must again publish the text of the regulation, as adopted, highlighting and explaining any substantial changes in the final regulation. A thirty-day final adoption period will commence upon publication in the *Virginia Register.*

The Governor will review the final regulation during this time and if he objects, forward his objection to the Registrar and the agency. His objection will be published in the *Virginia Register.* If the Governor finds that changes made to the proposed regulation are substantial, he may suspend the regulatory process for thirty days and require the agency to solicit additional public comment on the substantial changes.

A regulation becomes effective at the conclusion of this thirty-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 twenty-one day extension period; or (ii) the Governor exercises his authority to suspend the regulatory process for solicitation of additional public comment, in which event the regulation, unless withdrawn, becomes effective on the date specified which date shall be after the expiration of the period for which the Governor has suspended the regulatory process.

Proposed action on regulations may be withdrawn by the promulgating agency at any time before the regulation becomes final.

EMERGENCY REGULATIONS

If an agency determines that an emergency situation exists, it then requests the Governor to issue an emergency regulation. 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 in time and cannot exceed a twelve-months duration. The emergency regulations will be published as quickly as possible in the *Virginia Register.*

During the time the emergency status is in effect, the agency may proceed with the adoption of permanent regulations through the usual procedures (See "Adoption, Amendment, and Repeal of Regulations," above). If the agency does not choose 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 of Chapter 1.1:1 (§§ 9-6.14:6 through 9-6.14:9) 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. **1:3 VA.R. 75-77 November 12, 1984** refers to Volume 1, Issue 3, pages 75 through 77 of the Virginia Register issued on November 12, 1984.

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VIRGINIA REGISTER OF REGULATIONS

PUBLICATION DEADLINES AND SCHEDULES

March 1992 through June 1993

MATERIAL SUBMITTED BY Noon Wednesday	PUBLICATION DATE
Volume 8 - 1992	
Mar. 18	Apr. 6
Apr. 1	Apr. 20
Apr. 15	May 4
Apr. 29	May 18
May 13	June 1
May 27	June 15
June 10	June 29
Index 3 - Volume 8	
June 24	July 13
July 8	July 27
July 22	Aug. 10
Aug. 5	Aug. 24
Aug. 19	Sept. 7
Sept. 2	Sept. 21
Final Index - Volume 8	
Volume 9 - 1992-93	
Sept. 16	Oct. 5
Sept. 30	Oct. 19
Oct. 14	Nov. 2
Oct. 28	Nov. 16
Nov. 11	Nov. 30
Nov. 25	Dec. 14
Dec. 9	Dec. 28
Index 1 - Volume 9	
Dec. 23	Jan. 11, 1993
Jan. 6	Jan 25
Jan. 20	Feb. 8
Feb. 3	Feb. 22
Feb. 17	Mar. 1
Mar. 3	Mar. 15
Mar. 17	Mar. 29
Index 2 - Volume 9	
Mar. 31	Apr. 12
Apr. 14	Apr. 26
Apr. 28	May 10
May 12	May 24
May 26	June 7
June 9	June 21
June 16	June 28
Index 3 - Volume 9	

TABLE OF CONTENTS

NOTICES OF INTENDED REGULATORY ACTION

PROPOSED REGULATIONS

DEPARTMENT OF AIR POLLUTION CONTROL (STATE BOARD)

DEPARTMENT OF TRANSPORTATION (COMMONWEALTH TRANSPORTATION BOARD)

VIRGINIA HOUSING DEVELOPMENT AUTHORITY

FINAL REGULATIONS

CRIMINAL JUSTICE SERVICES BOARD

DEPARTMENT OF HOUSING AND COMMUNITY DEVELOPMENT (BOARD OF)

VIRGINIA HOUSING DEVELOPMENT AUTHORITY

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (BOARD OF)

Table of Contents

GENERAL NOTICES/ERRATA

CALENDAR OF EVENTS

Table of Contents

NOTICES OF INTENDED REGULATORY ACTION

Symbol Key †
† Indicates entries since last publication of the Virginia Register

STATE AIR POLLUTION CONTROL BOARD

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the State Air Pollution Control Board intends to consider amending regulations entitled: **VR 120-01. Regulations for the Control and Abatement of Air Pollution.** The purpose of the regulation is to limit or prohibit open burning in some instances and to establish requirements to allow the agency to monitor and issue permits for open burning in order to restrict particulate (smoke) emissions from open burning to the levels necessary for the protection of public health and welfare.

A public meeting will be held by the department in House Room 1, State Capitol Building, Richmond, Virginia, at 9 a.m. on June 24, 1992, to discuss the intended action. Unlike a public hearing, which is intended only to receive testimony, this meeting is being held to discuss and exchange ideas and information relative to regulation development.

Ad hoc advisory group: The department will form an ad hoc advisory group to assist in the development of the regulation. Persons desiring to be in the group should notify the agency contact in writing by close of business on May 21, 1992, providing the name, address, phone number, and the organization to be represented (if any). Notification of the composition of the ad hoc advisory group will be sent to all applicants by June 4, 1992. Person selected to be on the group are encouraged to attend the public meeting mentioned above and any subsequent meetings that may be needed to develop the draft regulation.

Location of documents: The legal and technical basis for the intended regulatory action and any supporting documents may be examined by the public on the Eighth Floor, Ninth Street Office Building, 200-202 North Ninth Street, Richmond, Virginia, between 8:30 a.m. and 4:30 p.m. of each business day until the day of the meeting.

Need and issues involved: The basic elements of Rule 4-40 are as follows. Section 120-04-4003 generally prohibits the burning of refuse (except as allowed by § 120-04-4004). Section 120-04-4003 also specifies conditions under which open burning is never allowed, such as the burning of rubber, asphaltic or oily materials, or toxic materials. Section 120-04-4004 contains the list of circumstances under which burning is allowed. In two of these circumstances, the burning of land clearing refuse and burning at local landfills, a permit is required in order to burn. Section 120-04-4005 covers the permitting of special open pit incinerators often used as an alternative to open burning. Essentially, Rule 4-40 does not prevent open burning but does impose restrictions designed to minimize the adverse effects of this activity.

Open burning produces a form of air pollution that is readily visible to the public and is therefore a very sensitive issue. Also, open burning presents an immediate and real health hazard to the public, especially to those with asthma, bronchitis, or other respiratory diseases. Moreover, control of open burning can sometimes involve a conflict between two public policy issues: the enjoyment of life and property and the promotion of economic development. For instance, a large open burn in a heavily populated area may cause a nuisance and hinder the enjoyment of private property, but at the same time it may reduce the expense of disposal.

On the other hand, emissions from open burning represent less than 1.0% of the total emissions statewide, but the time spent in dealing with the problem may range as high as 25% for some of the department's enforcement staff. This allocation of resources seems disproportionate in light of the department's responsibility to control other types of emissions which contribute far more to the degradation of air quality, like those from industry and motor vehicles. Therefore, the regulation of open burning on a statewide basis may not be cost effective.

Alternatives: The department is requesting comments on the costs and benefits of the following alternatives as well as on any others which address the need. The department's assessment of the following alternatives is presented below.

1. Take no action. This alternative would be inappropriate from the point of view of both public and department. Scarce resources prevent the department from devoting the necessary time and staff to the enforcement of the current rule. Local governments and the public, however, assume the existence of adequate enforcement efforts on the part of the state because of the language of the current rule.

2. Remove all state air quality restrictions on open burning except for those governing the burning of hazardous materials. This alternative would probably be unacceptable to the public. Since open burning is one of the most visible forms of air pollution, citizens

file complaints about this activity with great readiness. Furthermore, the department's abolition of the open burning restrictions might be perceived by the public as irrational and inconsistent in light of the fact that the department has worked to obtain several convictions for violation of the current open burning rule over the past years.

3. Prohibit all open burning. This alternative would be impossible to enforce. Department staff have already significantly reduced the amount of time spent investigating open burning complaints and issuing open burning permits because more important legal mandates demand that they spend their time enforcing rules that have a greater environmental and health impact than does the open burning rule. Open burning has no measurable effect on ambient air quality; therefore, statewide regulation contributes very little to Virginia's legal health and welfare goals. A more stringent rule (like one involving a prohibition of all open burning) would further widen the discrepancy between law and practice since sufficient resources could not possibly be allocated to enforce it.

4. Prohibit all open burning except where there is a valid local ordinance meeting criteria specified by the state. Since local waste collection and disposal policies significantly affect the practice of open burning, it is appropriate for the local governing bodies responsible for those policies to assume the authority for dealing with open burning within their jurisdictions. Such assumption of authority is realistic since little technical expertise is needed to enforce a local open burning ordinance. Furthermore, a local government could more consistently and efficiently enforce an open burning ordinance through its fire and police departments than the state could through nonlocal staff. The major caveat with this alternative is that local governments vary considerably in their capability and willingness to assume responsibility for open burning. Any attempt to force local control could result in strained relations with both the localities and the public.

Regulatory constraints: Section 10.1-1308 of the Virginia Air Pollution Control Law prohibits the board from regulating "the burning of leaves from trees by persons on property where they reside if the local governing body of the county, city or town has enacted an otherwise valid ordinance regulating such burning."

Applicable statutory provisions: The legal basis for the regulation is § 10.1-1308 of the Virginia Air Pollution Control Law (Chapter 13 of Title 10.1 of the Code of Virginia).

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

Written comments may be submitted until 4 p.m., June 24, 1992, to Director of Program Development, Department of Air Pollution Control, P.O. Box 10089, Richmond, VA 23240.

Contact: Kathleen Sands, Policy Analyst, Division of Program Development, Department of Air Pollution Control, P.O. Box 10089, Richmond, VA 23240, telephone (804) 225-2722.

ALCOHOLIC BEVERAGE CONTROL BOARD

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Alcoholic Beverage Control Board intends to consider amending regulations entitled: **VR 125-01-1 through VR 125-01-7. Regulations of the Virginia Alcoholic Beverage Control Board.** The purpose of the proposed action is to receive information from industry, the general public and licensees of the board concerning adopting, amending or repealing the board's regulations.

A public hearing will be held on October 28, 1992, at 10 a.m. in the First Floor Hearing Room, 2901 Hermitage Road, Richmond, Virginia, to receive comments from the public. (See notice in General Notices Section.)

Statutory Authority: §§ 4-7(1), 4-11, 4.36, 4-69, 4-69.2, 4-72.1, 4-98.14, 4-103(b) and 9-6.14:1 et seq. of the Code of Virginia.

Written comments may be submitted until June 29, 1992.

Contact: Robert N. Swinson, Secretary to the Board, P.O. Box 27491, Richmond, VA 23291, telephone (804) 367-0616.

STATE BOARD OF CORRECTIONS

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the State Board of Corrections intends to consider amending regulations entitled: **VR 230-01-003. Rules and Regulations Governing the Certification Process.** The purpose of the proposed action is to update the rules and regulations used in the evaluation and certification of state and local correctional facilities.

Statutory Authority: §§ 53.1-5, 53.1-69, 53.1-144 and 53.1-178 of the Code of Virginia.

Written comments may be submitted until June 15, 1992.

Contact: James S. Jones, Jr., Manager, 6900 Atmore Drive, Richmond, VA 23225, telephone (804) 674-3262.

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's

public participation guidelines that the Board of Corrections intends to consider amending regulations entitled: **VR 230-30-007. Supervision Fee Rules, Regulations and Procedures.** The purpose of the proposed action is to bring the rules and regulations into compliance with changes to § 53.1-150 of the Code of Virginia, enacted during the 1992 session.

Statutory Authority: §§ 53.1-5 and 53.1-150 of the Code of Virginia.

Written comments may be submitted until June 22, 1992.

Contact: Walter M. Pulliam, Regional Administrator, 302 Turner Road, Richmond, VA 23225-6432, telephone (804) 674-3732.

VIRGINIA HEALTH SERVICES COST REVIEW COUNCIL

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Virginia Health Services Cost Review Council intends to consider amending regulations entitled: **VR 370-01-001. Rules and Regulations of the Virginia Health Services Cost Review Council.** The purpose of the proposed action is to amend regulations to reflect 1992 amendments of § 9-160 D pertaining to the Council's Commercial Diversification Survey and the new requirements for the Council to collect Form 990s from nonprofit health care institutions.

Statutory Authority: §§ 9-160 and 9-164 of the Code of Virginia, as amended by the 1992 Session of the Virginia General Assembly.

Written comments may be submitted until June 22, 1992.

Contact: John A. Rupp, Executive Director, Virginia Health Services Cost Review Council, 805 E. Broad Street, 6th Floor, Richmond, VA 23219, telephone (804) 786-6371.

DEPARTMENT OF HISTORIC RESOURCES

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Department of Historic Resources intends to consider promulgating regulations entitled: **VR 390-01-01:2. Public Participation Guidelines.** The purpose of the proposed action is to adopt Public Participation Guidelines for the department which establish, in regulation, various provisions to ensure interested parties have the necessary information to comment on regulatory actions in a meaningful fashion in all phases of the regulatory process and establish regulations which are consistent with those of the other agencies within the Natural Resources Secretariat. Specifically, the department is considering adoption of Public Participation Guidelines which would require an expanded notice of intended regulatory action (NOIRA) to include a statement as to the need for the regulatory action; a description, if possible, of alternatives available to meet the need; and a request for comments on the intended regulatory action, comments on the costs and benefits of the alternatives, and suggestions. In addition, the department would be required to perform certain analyses and state in the notice of public comment period that the analyses had been performed and are available to the public upon request.

Section 9-6.14:7.1 of the Code of Virginia requires each agency to develop, adopt and utilize public participation guidelines for soliciting the input of interested parties in the formation and development of its regulations. Sections 10.1-2202 authorizes the director of the Department of Historic Resources to promulgate regulations necessary to carry out all responsibilities incumbent upon the State Historic Preservation Officer, including at a minimum criteria and procedures for submitting nominations of properties to the National Park Service for inclusion in the National Register of Historic Places or for designation as National Historic Landmarks.

No financial impact on regulated entities or the public is expected from the intended regulatory action since the guidelines only impose requirements on the department. Regulated entities and the public should benefit from the intended regulatory action in that the guidelines used by the different environmental agencies will be consistent and the amount and types of information made available to regulated entities and the public for their use in participating in the regulatory process will increase and be required by regulations.

The department will hold a public meeting at 2 p.m., Thursday, June 18, 1992, in the board room, Department of Historic Resources, 221 Governor Street, Richmond, Virginia, to receive views and comments and to answer questions of the public.

Statutory Authority: §§ 9-6.14:7.1 and 10.1-2202 of the Code of Virginia.

Written comments may be submitted until 4 p.m., June 22, 1992.

Contact: H. Bryan Mitchell, Deputy Director, 221 Governor Street, Richmond, VA 23219, telephone (804) 786-3143.

DEPARTMENT OF HOUSING AND COMMUNITY DEVELOPMENT (BOARD OF)

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Housing and Community Development intends to consider amending regulations entitled: **VR 394-01-02. Virginia Tradesmen**

Certification Standards. The purpose of the proposed action is to amend §§ 4.2, 4.3, 4.5 and 4.6 regarding two classifications of blaster certification – restricted and unrestricted, and § 4.4 (Temporary certification)

Statutory Authority: § 15.1-11.4 of the Code of Virginia.

Written comments may be submitted until June 12, 1992.

Contact: Jack A. Proctor, Deputy Director, 205 N. 4th Street, Richmond, VA 23219, telephone (804) 371-7772.

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Housing and Community Development intends to consider amending regulations entitled: **VR 394-01-04. Virginia Uniform Statewide Building Code Amusement Device Regulation.** The purpose of the proposed action is to amend those portions pertaining to passenger tramway (ski-lift) regulations; kiddie rides (types A & B); and accidents involving serious injury or fatality.

Statutory Authority: § 36-98.3 of the Code of Virginia.

Written comments may be submitted until June 12, 1992.

Contact: Jack A. Proctor, Deputy Director, 205 N. 4th Street, Richmond, VA 23219, telephone (804) 371-7772.

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Housing and Community Development intends to consider amending regulations entitled: **VR 394-01-06. Virginia Statewide Fire Prevention Code.** The purpose of the proposed action is to amend § F-102.1 (written enforcement notification) and § F-102.1 (Modifications).

Statutory Authority: §§ 27-95 and 27-97 of the Code of Virginia.

Written comments may be submitted until June 12, 1992.

Contact: Jack A. Proctor, Deputy Director, 205 N. 4th Street, Richmond, VA 23219, telephone (804) 371-7772.

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Housing and Community Development intends to consider amending regulations entitled: **VR 394-01-21. Virginia Uniform Statewide Building Code Volume I, New Construction.** The purpose of the proposed action is to amend those portions pertaining to: §§ 105.6 (Plans review), 201.0 and 309.4.1 (family day care homes), 112.0 (violations), 120.3 and 201.0 (public nuisance), 512.0 (accessibility), 1300.4 and R-221 (lead based paint), 2700.5 and R-220 (telephone jack pre-wiring), P-1503.8, P-1503.9 - Adden. 1 and P-2301 - Adden. 2 (Water conservation).

Statutory Authority: §§ 36-98 and 36-99 of the Code of Virginia.

Written comments may be submitted until June 12, 1992.

Contact: Jack A. Proctor, Deputy Director, 205 N. 4th Street, Richmond, VA 23219, telephone (804) 371-7772.

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Housing and Community Development intends to consider amending regulations entitled: **VR 394-01-22. Virginia Uniform Statewide Building Code Volume II, Property Maintenance.** The purpose of the proposed action is to amend those portions pertaining to: §§ 101.4 (Application of model codes), 104.0 (violations), 105.8 (Abatement or removal), 109.5 (Identification of handicapped parking spaces, and PM-303.4 (Lead based paint).

Statutory Authority: §§ 36-98 and 36-99 of the Code of Virginia.

Written comments may be submitted until June 12, 1992.

Contact: Jack A. Proctor, Deputy Director, 205 N. 4th Street, Richmond, VA 23219, telephone (804) 371-7772.

DEPARTMENT OF LABOR AND INDUSTRY

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Department of Labor and Industry intends to consider amending regulations entitled: **VR 425-01-80. Virginia Hours of Work for Minors.** The purpose of the proposed amendment it to extend the requirement regarding hours of work, including the number of hours per week, the number of hours per day, and the hours of day applicable to minors working in nonagricultural employment to minors working on farms, in gardens and in orchards or to otherwise extend hours of work restrictions on such minors.

Statutory Authority: §§ 40.1-6 and 40.1-80.1 of the Code of Virginia.

Written comments may be submitted until June 22, 1992.

Contact: Dennis Merrill, Labor Law Director, Department of Labor and Industry, Powers-Taylor Building, 13 S. Thirteenth Street, Richmond, VA 23219, telephone (804) 786-3224.

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Department of Labor and Industry intends to consider amending regulations entitled: **VR 425-01-81. Regulation Governing the Employment of Minors on Farms, in Gardens and in Orchards.** The purpose of the proposed action is to address the need for additional safeguards on the occupational use of agricultural chemicals and toxic substances by minors on farms, in gardens and in orchards. Public comments received by the department as part of the promulgation of this regulation indicated the need to further explore this issue.

Given the technical nature of the issue raised, insufficient time existed during the regulatory promulgation period to adequately explore this issue and retain the scheduled July 1, 1992, effective date. Current emergency regulations expire on June 30, 1992. This issue is therefore being addressed in a separate rulemaking.

Statutory Authority: §§ 40.1-6, 40.1-100 A and 40.1-114 of the Code of Virginia.

Written comments may be submitted until June 20, 1992.

Contact: Dennis Merrill, Labor Law Director, Department of Labor and Industry, Powers-Taylor Building, 13 S. Thirteenth Street, Richmond, VA 23219, telephone (804) 786-3224.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (BOARD OF)

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Medical Assistance Services intends to consider amending regulations entitled: **VR 460-03-3.1105. Drugs or Drug Categories Which are Not Covered (Attachment 3.1 A & B, Supplement 5).** The purpose of the proposed action is to promulgate regulations for the exclusion from Medicaid payment drugs which are used for cosmetic purposes and drugs which are used for fertility and infertility services.

Statutory Authority: § 32.1-325 of the Code of Virginia.

Written comments may be submitted until June 15, 1992, to Rebecca Miller, Pharmacy Consultant, Division of Policy and Research, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia.

Contact: Victoria Simmons, Regulatory Coordinator, Division of Policy and Research, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219, telephone (804) 786-7933.

BOARD OF MEDICINE

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Medicine intends to consider amending regulations entitled: **VR 465-02-1. Regulations Governing the Practice of Medicine, Osteopathy, Podiatry, Chiropractic, Clinical Psychology, and Acupuncture.** The purpose of the proposed action is to amend § 1.7 to further define misleading or deceptive advertising; to amend § 3.1 to further define the components required to be eligible to sit for the United States Medical Licensing Examination; and to amend § 4.1 by defining additional examinations acceptable for licensure examinations and establishing a period of time for passing the required examinations.

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

Written comments may be submitted until July 2, 1992, to Hilary H. Connor, M.D., Executive Director, Board of Medicine, 1601 Rolling Hills Drive, Richmond, Virginia.

Contact: Eugenia K. Dorson, Deputy Executive Director, 1601 Rolling Hills Drive, Richmond, VA 23229, telephone (804) 662-9923.

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Medicine intends to consider amending regulations entitled: **VR 465-02-1. Regulations Governing the Practice of Medicine, Osteopathy, Podiatry, Chiropractic, Clinical Psychology, and Acupuncture.** The purpose of the proposed action is to develop regulations relating to chelation therapy.

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

Written comments may be submitted until June 3, 1992, to Hilary H. Connor, M.D., Executive Director, Board of Medicine, 1601 Rolling Hills Drive, Richmond, Virginia.

Contact: Eugenia K. Dorson, Deputy Executive Director, 1601 Rolling Hills Drive, Richmond, VA 23229, telephone (804) 662-9923.

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Medicine intends to consider amending regulations entitled: **VR 465-05-1. Regulations Governing the Practice of Physician's Assistants.** The purpose of the proposed action is to respond to Senate Bill 192 to allow precriptive authority for physician's assistants.

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

Written comments may be submitted until June 19, 1992, to Hilary H. Connor, M.D., Executive Director, Board of Medicine, 1601 Rolling Hills Drive, Richmond, Virginia.

Contact: Eugenia K. Dorson, Deputy Executive Director, 1601 Rolling Hills Drive, Richmond, VA 23229, telephone (804) 662-9923.

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Medicine intends to consider amending regulations entitled: **VR 465-08-01. Regulations for Certification of Occupational Therapists.** The purpose of the proposed action is to amend §§ 2.2 and 2.3, Certification by Examination, to further define the educational requirements.

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

Written comments may be submitted until July 2, 1992, to Hilary H. Connor, M.D., Executive Director, Board of Medicine, 1601 Rolling Hills Drive, Richmond, Virginia.

Contact: Eugenia K. Dorson, Deputy Executive Director, 1601 Rolling Hills Drive, Richmond, VA 23229, telephone (804) 662-9923.

DEPARTMENT OF MOTOR VEHICLES

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Department of Motor Vehicles intends to consider promulgating regulations entitled: **Salvage Act Regulations.** The purpose of the proposed action is to implement the Salvage Act.

Statutory Authority: § 46.2-203 of the Code of Virginia.

Written comments may be submitted until June 8, 1992.

Contact: L. Steve Stupasky, Program Manager, P.O. Box 27412, Richmond, VA 23269-0001, telephone (804) 367-1939.

DEPARTMENT OF STATE POLICE

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Department of State Police intends to consider amending regulations entitled: **VR 545-01-07. Motor Vehicle Safety Inspection Rules and Regulations.** The purpose of the proposed action is to (i) clarify the active life of Class IV offenses and identify combinations of lesser offenses committed during the active life of any Class IV offense that constitute grounds for suspension from the inspection program; (ii) prohibit vehicle modifications that raise a vehicle's body more than three inches above the manufacturer's attachment points or frame rail, excluding the original manufacturer's spacers, washers or bushings; (iii) adopt the standards and specifications of the Society of Automotive Engineers, Inc., and the Federal Motor Vehicle Safety Standard No. 209 for motor vehicle seat belt anchorages and attachment hardware; (iv) permit the use of a stop signal arm consisting of an octagonal sign on school buses which meets Federal Motor Vehicle Safety Standards – the sign will be reflectorized or equipped with 2 red warning lights of an approved type; (v) revise the steering lash/travel standard for trucks to parallel federal standards governing steering wheel movements; (vi) delete that portion of the table setting forth the minimum criteria for brake adjustment that specifies push rod limits for air disc brakes; and (vii) revise the Approved Equipment Section to include the definitions for safety glass and safety glazing materials as abstracted from the Z26.1-1990 glazing standard adopted by the American National Standards, Inst. and Federal Motor Vehicle Safety Standard #205.

Statutory Authority: §§ 46.2-1002, 46.2-1056, 46.2-1058, 46.2-1063, 46.2-1065, 46.2-1070, 46.2-1093, 46.2-1163 and 46.2-1165 of the Code of Virginia.

Written comments may be submitted until June 20, 1992.

Contact: Captain J. P. Henries, Safety Officer, Department of State Police, Safety Divison, P.O. Box 85607, Richmond, VA 23285-5607, telephone (804) 674-2017.

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Department of State Police intends to consider amending regulations entitled: **Standards and Specification for the Stickers or Decals Used by Counties, Cities and Towns in Lieu of License Plates.** The purpose of the proposed action is to make these standards and specifications consistent with existing state law and Motor Vehicle Safety Inspection Rules and Regulations with regards to sticker or decal placement.

Statutory Authority: § 46.2-1052 of the Code of Virginia.

Written comments may be submitted until June 20, 1992.

Contact: Captain J. P. Henries, Safety Officer, Department of State Police, Safety Divison, P.O. Box 85607, Richmond, VA 23285-5607, telephone (804) 674-2017.

DEPARTMENT OF SOCIAL SERVICES (BOARD OF)

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Social Services intends to consider promulgating regulations entitled: **VR 615-32-01:1. Child Day Care Scholarship Programs.** The purpose of the proposed action is to provide guidelines for federal Child Care Provider Scholarship Program.

Statutory Authority: § 63.1-25 of the Code of Virginia.

Written comments may be submitted until June 18, 1992.

Contact: Peggy Friedenberg, Legislative Analyst, Bureau of Governmental Affairs, 8007 Discovery Drive, Richmond, VA 23229-8699, telephone (804) 662-9217.

BOARD FOR PROFESSIONAL SOIL SCIENTISTS

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board for Professional Soil Scientists intends to consider amending regulations entitled: **VR 627-02-1. Board for Professional Soil Scientists Regulations.** The purpose of the proposed action is to conduct a biennial review of the regulations and to adjust fees.

Statutory Authority: §§ 54.1-201 and 54.1-2200 et seq. of the Code of Virginia.

Written comments may be submitted until June 4, 1992.

Contact: Nelle P. Hotchkiss, Assistant Director, Virginia Department of Commerce, 3600 W. Broad Street, Richmond, VA 23230, telephone (804) 367-8595.

For information concerning Proposed Regulations, see information page.

Symbol Key

Roman type indicates existing text of regulations. *Italic type* indicates proposed new text. Language which has been stricken indicates proposed text for deletion.

DEPARTMENT OF AIR POLLUTION CONTROL (STATE BOARD OF)

Title of Regulation: **VR 120-01. Regulations for the Control and Abatement of Air Pollution - Emission Standards for Volatile Organic Compounds and Nitrogen Oxides from Stationary Sources.**

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

Public Hearing Date: July 15, 1992 - 10 a.m.
(See Calendar of Events section for additional information)

Summary:

The regulation amendments concern provisions covering emission standards for volatile organic compounds (VOC) and nitrogen oxides (NOx) from stationary sources and are summarized below:

A. Reporting requirements for emissions from stationary sources of VOC and NOx.

Revise the provisions covering the submittal of registration information (§ 120-02-31) to require emission statements for stationary sources emitting 25 tons per year or more of VOC and NOx in any of the emissions control areas.

B. Emission standards for stationary sources of VOC and NOx.

1. Expand the VOC Emissions Control Areas (Appendix P) to include all of the new nonattainment localities in the Northern Virginia and Richmond Nonattainment Areas and establish new NOx Emission Control Areas (Appendix P) to include all of the same localities as in the expanded VOC Emissions Control Areas.

2. Revise the existing VOC emission standard (§ 120-04-0407) for non-CTG sources to require reasonable available control technology (RACT) for all sources emitting 50 tons per year or greater of VOC in the Northern Virginia emissions control area.

3. Establish a NOx emission standard (§ 120-04-0408) for non-CTG sources to require RACT for:

a. All sources emitting 50 tons per year or greater of NOx in the Northern Virginia emissions contrtol area; and

b. All sources emitting 100 tons per year or greater of NOx in the Richmond emissions control area.

VR 120-01. Regulations for the Control and Abatement of Air Pollution - Emission Standards for Volatile Organic Compounds and Nitrogen Oxides from Stationary Sources.

PART I.
GENERAL DEFINITIONS.

§ 120-01-01. General.

A. For the purpose of these regulations and subsequent amendments or any orders issued by the board, the words or terms shall have the meanings given them in § 120-01-02.

B. Unless specifically defined in the Virginia Air Pollution Control Law or in these regulations, terms used shall have the meanings commonly ascribed to them by recognized authorities.

C. In addition to the definitions given in this part, some other major divisions (i.e. parts, rules, etc.) of these regulations have within them definitions for use with that specific major division.

§ 120-01-02. Terms defined.

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

"Administrative Process Act" means Chapter 1.1:1 (§ 9-6.14:1 et seq.) of Title 9 of the Code of Virginia.

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

"Affected facility" means, with reference to a stationary source, any part, equipment, facility, installation, apparatus, process or operation to which an emission standard is applicable or any other facility so designated.

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

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

"Air quality control region" means any area designated as such in Appendix B.

"Air quality maintenance area" means any area which, due to current air quality or projected growth rate or both, may have the potential for exceeding any ambient air quality standard set forth in Part III within a subsequent 10-year period and designated as such in Appendix H.

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

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

"Ambient air quality standard" means any primary or secondary standard designated as such in Part III.

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

"Class I area" means any prevention of significant deterioration area designated as such in Appendix L.

"Class II area" means any prevention of significant deterioration area designated as such in Appendix L.

"Class III area" means any prevention of significant deterioration area designated as such in Appendix L.

"Consent agreement" means an agreement that the owner or any other person will perform specific actions for the purpose of diminishing or abating the causes of air pollution or for the purpose of coming into compliance with these regulations, by mutual agreement of the owner or any other person and the board.

"Consent order" means a consent agreement issued as an order. Such orders may be issued without a hearing.

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

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

1. The date by which contracts for emission control system or process modifications are to be awarded, or the date by which orders are to be issued for the purchase of component parts to accomplish emission control or process modification.

2. The date by which the on-site construction or installation of emission control equipment or process change is to be initiated.

3. The date by which the on-site construction or installation of emission control equipment or process modification is to be completed.

4. The date by which final compliance is to be achieved.

"Criteria pollutant" means any pollutant for which an ambient air quality standard is established under Part III.

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

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

"Department" means any employee or other representative of the Virginia Department of Air Pollution Control, as designated by the executive director.

"Dispersion technique"

1. Means any technique which attempts to affect the concentration of a pollutant in the ambient air by:

a. Using that portion of a stack which exceeds good engineering practice stack height;

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

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

2. The preceding sentence does not include:

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

b. The merging of exhaust gas streams where:

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

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

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

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

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

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

"Emergency" means a situation that immediately and unreasonably affects, or has the potential to immediately and unreasonably affect, public health, safety or welfare; the health of animal or plant life; or property, whether used for recreational, commercial, industrial, agricultural or other reasonable use.

"Emergency special order" means any order of the board issued under the provisions of § 10.1-1309 B, after declaring a state of emergency and without a hearing, to owners who are permitting or causing air pollution, to cease such pollution. Such orders shall become invalid if an appropriate hearing is not held within 10 days after the effective date.

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

"Emission standard" means any provision of Parts IV, V or VI which prescribes an emission limitation, or other requirements that control air pollution emissions.

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

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

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

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

1. For sources seeking credit for stack height exceeding that established under subdivision 2 of the GEP definition, a maximum ground-level concentration due to emissions from a stack due in whole or part to downwash, wakes, and eddy effects produced by nearby structures or nearby terrain features which individually is at least 40% in excess of the maximum concentration experienced in the absence of such downwash, wakes, or eddy effects and which contributes to a total concentration due to emissions from all sources that is greater than an ambient air quality standard. For sources subject to the provisions of § 120-08-02, an excessive concentration alternatively means a maximum ground-level concentration due to emissions from a stack due in whole or part to downwash, wakes, or eddy effects produced by nearby structures or nearby terrain features which individually is at least 40% in excess of the maximum concentration experienced in the absence of the maximum concentration experienced in the absence of such downwash, wakes, or eddy effects and greater than a prevention of significant deterioration increment. The allowable emission rate to be used in making demonstrations under this provision shall be prescribed by the new source performance standard that is applicable to the source category unless the

owner demonstrates that this emission rate is infeasible. Where such demonstrations are approved by the board, an alternative emission rate shall be established in consultation with the owner;

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

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

"Executive director" means the executive director of the Virginia Department of Air Pollution Control or his designated representative.

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

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

"Federal Clean Air Act" means 42 USC 7401 et seq., 91 Stat 685.

"Good engineering practice" (GEP) stack height means the greater of:

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

2. a. For stacks in existence on January 12, 1979, and for which the owner had obtained all applicable permits or approvals required under Part VIII,

$$Hg = 2.5H,$$

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

b. For all other stacks,

$$Hg = H + 1.5L,$$

where:

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

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

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

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

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

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

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

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

"Metropolitan statistical area" means any area designated as such in Appendix G.

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

"Nearby" as used in the definition of good engineering

practice (GEP) is defined for a specific structure or terrain feature and

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

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

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

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

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

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

"Order" means any decision or directive of the board, including special orders, emergency special orders and orders of all types, rendered for the purpose of diminishing or abating the causes of air pollution or enforcement of these regulations. Unless specified otherwise in these regulations, orders shall only be issued after the appropriate hearing.

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

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

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

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

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

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

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

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

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

"Prevention of significant deterioration area" means any area not designated as a nonattainment area in Appendix K for a particular pollutant and designated as such in Appendix L.

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

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

1. For ambient air quality standards in Part III: the applicable appendix of 40 CFR Part 50 or any method that has been designated as a reference method in accordance with 40 CFR Part 53, except that it does not include a method for which a reference designation has been ~~cancelled~~ *canceled* in accordance with 40 CFR 53.11 or 40 CFR 53.16.

2. For emission standards in Parts IV and V: Appendix A of 40 CFR Part 60.

3. For emission standards in Part VI: Appendix B of 40 CFR Part 61.

"Regional director" means the regional director of an administrative region of the Department of Air Pollution

Control or his designated representative.

"Reid vapor pressure" means the absolute vapor pressure of volatile crude oil and volatile nonviscous petroleum liquids except liquefied petroleum gases as determined by American Society for Testing and Materials, Standard D323-82, Test Method for Vapor Pressure of Petroleum Products (Reid Method) (see Appendix M).

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

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

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

"Special order" means any order of the board issued:

1. Under the provisions of § 10.1-1309:

a. To owners who are permitting or causing air pollution to cease and desist from such pollution;

b. To owners who have failed to construct facilities in accordance with or have failed to comply with plans for the control of air pollution submitted by them to, and approved by the board, to construct such facilities in accordance with or otherwise comply with such approved plan;

c. To owners who have violated or failed to comply with the terms and provisions of any order or directive issued by the board to comply with such terms and provisions;

d. To owners who have contravened duly adopted and promulgated air quality standards and policies to cease and desist from such contravention and to comply with such air quality standards and policies; and

e. To require any owner to comply with the provisions of this chapter and any decision of the board; or

2. Under the provisions of § 10.1-1309.1 requiring that an owner file with the board a plan to abate, control, prevent, remove, or contain any substantial and imminent threat to public health or the environment that is reasonably likely to occur if such source ceases operations.

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

"Stack in existence" means that the owner had:

1. Begun, or caused to begin, a continuous program of physical on site construction of the stack; or

2. Entered into binding agreements or contractual obligations, which could not be ~~cancelled~~ *canceled* or modified without substantial loss to the owner, to undertake a program of construction of the stack to be completed in a reasonable time.

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

"Standard of performance" means any provision of Part V which prescribes an emission limitation or other requirements that control air pollution emissions.

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

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

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

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

"True vapor pressure" means the equilibrium partial pressure exerted by a petroleum liquid as determined in accordance with methods described in American Petroleum Institute (API) Publication 2517, Evaporation Loss from External Floating-Roof Tanks (see Appendix M). The API procedure may not be applicable to some high viscosity or high pour crudes. Available estimates of true

vapor pressure may be used in special cases such as these.

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

"Vapor pressure," except where specific test methods are specified, means true vapor pressure, whether measured directly, or determined from Reid vapor pressure by use of the applicable nomograph in API Publication 2517, Evaporation Loss from External Floating-Roof Tanks (see Appendix M).

"Variance" means the temporary exemption of an owner or other person from these regulations, or a temporary change in these regulations as they apply to an owner or other person.

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

"Virginia Register Act" means Chapter 1.2 (§ 9-6.15 et seq.) of Title 9 of the Code of Virginia.

~~*"Volatile organic compound"* means any organic compound which participates in atmospheric photochemical reactions and is measured by the applicable reference method. The following compounds are exempted from this definition:~~

~~1. Methane~~

~~2. Ethane~~

~~3. 1,1,1-trichloroethane (methyl chloroform)~~

~~4. Methylene chloride~~

~~5. Trichlorofluoromethane (CFC-11)~~

~~6. Dichlorodifluoromethane (CFC-12)~~

~~7. Chlorodifluoromethane (CFC-22)~~

~~8. Trifluoromethane (FC-23)~~

~~9. 1,1,2-trichlorotrifluoroethane (CFC-113)~~

~~10. 1,2-dichlorotetrafluoroethane (CFC-114)~~

~~11. Chloropentafluoroethane (CFC-115)~~

~~12. Dichlorotrifluoroethane (HCFC-123)~~

~~13. Tetrafluoroethane (HFC-134a)~~

~~14. Dichlorofluoroethane (HCFC-141b)~~

~~15. Chlorodifluoroethane (HCFC-142b)~~

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

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

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

a. Methane;

b. Ethane;

c. Methylene chloride (dichloromethane);

d. 1,1,1-trichloroethane (methyl chloroform);

e. 1,1,1-trichloro-2,2,2-trifluoroethane (CFC-113);

f. Trichlorofluoromethane (CFC-11);

g. Dichlorodifluoromethane (CFC-12);

h. Chlorodifluoromethane (CFC-22);

i. Trifluoromethane (FC-23);

j. 1,2-dichloro 1,1,2,2,-tetrafluoroethane (CFC-114);

k. Chloropentafluoroethane (CFC-115);

l. 1,1,1-trifluoro 2,2-dichloroethane (HCFC-123);

m. 1,1,1,2-tetrafluoroethane (HFC-134a);

n. 1,1-dichloro 1-fluoroethane (HCFC-141b);

o. 1-chloro 1,1-difluoroethane (HCFC-142b);

p. 2-chloro-1,1,1,2-tetrafluoroethane (HCFC-124);

q. Pentafluoroethane (HFC-125);

r. 1,1,2,2-tetrafluoroethane (HFC-134);

s. 1,1,1-trifluoroethane (HFC-143a);

t. 1,1-difluoroethane (HFC-152a); and

u. Perfluorocarbon compounds which fall into these classes:

(1) Cyclic, branched, or linear, completely fluorinated alkanes;

(2) Cyclic, branched, or linear, completely fluorinated ethers with no unsaturations;

(3) Cyclic, branched, or linear, completely fluorinated tertiary amines with no unsaturations; and

(4) Sulfur containing perfluorocarbons with no unsaturations and with sulfur bonds only to carbon and fluorine.

2. For purposes of determining compliance with emissions standards, volatile organic compounds shall be measured by the appropriate reference method in accordance with the provisions of § 120-04-03 or § 120-05-03, as applicable. Where such a method also measures compounds with negligible photochemical reactivity, these negligible-reactive compounds may be excluded as a volatile organic compound if the amount of such compounds is accurately quantified, and such exclusion is approved by the board.

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

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

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

PART II.
GENERAL PROVISIONS.

§ 120-02-01. Applicability.

A. The provisions of these regulations, unless specified otherwise, shall apply throughout the Commonwealth of Virginia.

B. The provisions of these regulations, unless specified otherwise, shall apply to only those pollutants for which ambient air quality standards are set forth in Part III or for which emission standards are set forth in Parts IV, V and VI or both.

C. No provision of these regulations shall limit the power of the board to take such appropriate action as necessary to control and abate air pollution in emergency situations.

D. By the adoption of these regulations, the board confers upon the department the administrative, enforcement and decision making authority enumerated therein.

§ 120-02-02. Establishment of regulations and orders.

A. Regulations for the Control and Abatement of Air Pollution are established to implement the provisions of the Virginia Air Pollution Control Law and the federal Clean Air Act.

B. Regulations for the Control and Abatement of Air Pollution shall be adopted, amended or repealed in accordance with the provisions of § 10.1-1308 of the Virginia Air Pollution Control Law, Articles 1 and 2 of the Administrative Process Act and the Public Participation Guidelines in Appendix E.

C. Regulations, amendments and repeals shall become effective as provided in § 9-6.14:9.3 of the Administrative Process Act, except in no case shall the effective date be less than 60 days after adoption by the board.

D. If necessary in an emergency situation, the board may adopt, amend or stay a regulation as an exclusion under § 9-6.14:6 of the Administrative Process Act, but such rule or regulation shall remain effective no longer than 60 days unless readopted following the requirements of subsection B of this section. The provisions of this subsection are not applicable to emergency special orders; such orders are subject to the provisions of subsection F of this section.

E. The Administrative Process Act and Virginia Register Act provide that state regulations may incorporate documents by reference. Throughout these regulations, documents of the types specified below have been incorporated by reference.

1. United States Code.

2. Code of Virginia.

3. Code of Federal Regulations.

4. Federal Register.

5. Technical and scientific reference documents.

Additional information on the specific documents incorporated and their availability may be found in Appendix M.

F. Orders, special orders and emergency special orders may be issued pursuant to § 10.1-1307 D or § 10.1-1309 of the Virginia Air Pollution Control Law.

§ 120-02-03. Enforcement of regulations and orders.

A. Whenever the executive director or his designated representative has reason to believe that a violation of any provision of these regulations or any order has occurred, notice shall be served on the alleged violator or violators, citing the applicable provision of these regulations or the order involved and the facts on which the violation is based. The executive director or his designated representative may act as the agent of the board to obtain compliance through either of the following enforcement proceedings:

1. Administrative proceedings. The executive director or his designated representative may negotiate to obtain compliance through administrative means. Such means may be a variance, control program, consent agreement or any other mechanism that mandates compliance by a specific date. The means and the associated date shall be determined on a case-by-case basis and shall not allow an unreasonable delay in compliance. In cases where the use of an administrative means is expected to result in compliance within 90 days or less, preferential consideration shall be given to the use of a consent agreement. Unless specified otherwise in these regulations, the administrative means shall be approved by the board.

2. Judicial proceedings. The executive director or his designated representative may obtain compliance through legal means pursuant to § 10.1-1316 or § 10.1-1320 of the Virginia Air Pollution Control Law.

B. Nothing in this section shall prevent the executive director or his designated representative from making efforts to obtain voluntary compliance through conference, warning or other appropriate means.

C. Orders, consent orders, delayed compliance orders, special orders and emergency special orders are considered administrative means, and the board reserves the right to use such means in lieu of or to provide a legal basis for the enforcement of any administrative means negotiated or approved by the executive director or his designated representative under subsection A of this section.

D. Any enforcement proceeding under this section may be used as a mechanism to insure that the compliance status of any source is reasonably maintained by the owner.

§ 120-02-04. Hearings and proceedings.

A. Hearings and proceedings by the board may take any of the following forms:

1. The public hearing and informational proceeding required before considering regulations or variances, in accordance with §§ 10.1-1307 C and 10.1-1308 of the Virginia Air Pollution Control Law. The procedure for a public hearing and informational proceeding shall conform to § 9-6.14:7 of the Administrative Process Act, except as modified by §§ 10.1-1307 C and F and 10.1-1308 of the Virginia Air Pollution Control Law.

2. The informal fact finding proceeding which, with all parties consenting, may be used to ascertain facts upon which decisions of the board are based, in accordance with § 9-6.14:11 of the Administrative Process Act. The procedure for an informal fact finding proceeding shall conform to § 9-6.14:11 of the Administrative Process Act.

3. The formal hearing for the determination of violations, and for the enforcement or review of its orders and regulations, in accordance with § 10.1-1307 D and F of the Virginia Air Pollution Control Law. The procedure for a formal hearing shall conform to § 9-6.14:12 of the Administrative Process Act, except as modified by § 10.1-1307 D and F of the Virginia Air Pollution Control Law.

4. The special order hearing or emergency special order hearing for the determination of violations, and for the enforcement or review of its orders and regulations, in accordance with § 10.1-1309 of the Virginia Air Pollution Control Law. The procedures for the special order hearing or emergency special order hearing shall conform to § 9-6.14:12 of the Administrative Process Act, except as modified by § 10.1-1309 the Virginia Air Pollution Control Law.

B. Records of hearings by the board may be kept in either of the following forms:

1. Oral statements or testimony at any public hearing or informational proceeding will be stenographically or electronically recorded, and may be transcribed to written form.

2. Formal hearings and hearings for the issuance of special orders or emergency special orders will be recorded by a court reporter, or electronically recorded for transcription to written form.

C. Availability of record of hearings by the board.

1. A copy of the transcript of a public hearing or

informational proceeding, if transcribed, will be provided within a reasonable time to any person upon receipt of a written request and payment of the cost; if not transcribed, the additional cost of preparation will be paid by the person making the request.

2. Any person desiring a copy of the transcript of a special order, emergency special order or formal hearing recorded by a court reporter may purchase the copy directly from the court reporter; if not transcribed, the additional cost of preparation will be paid by the person making the request.

§ 120-02-05. Variances.

A. General.

1. Pursuant to § 10.1-1307 C of the Virginia Air Pollution Control Law, the board at its discretion may grant variances to any provision of these regulations after a public hearing in accordance with § 120-02-04 A 1.

2. Notices of public hearings on applications for variances shall be advertised in at least one major newspaper of general circulation in the affected air quality control region at least 30 days prior to the date of the hearing.

B. Fuel variance.

1. Regardless of any other provision of this section, the executive director may grant a fuel variance for fuel burning equipment from applicable provisions of these regulations if, after a thorough investigation and public hearing, he finds that:

a. The owner, in good faith and prior to the request for the fuel variance, has attempted to comply with applicable provisions of these regulations.

b. The owner has substantial cause to believe he will be unable to obtain the fuel to operate the equipment in compliance with applicable provisions of these regulations.

c. The maximum particulate and sulfur dioxide emissions from fuels permitted in the fuel variance would be the lowest that the available fuels will permit.

d. The need for the requested fuel variance could not have been avoided by the owner.

e. The period of the fuel variance will not exceed the reasonably predicted shortage of fuel which would allow compliance with these regulations, or 120 days, whichever is less.

2. The owner requesting the fuel variance shall submit the following, where appropriate, to the executive director:

a. The requested commencement and termination dates of the fuel variance.

b. The type and quantity of fuel to be used under the requested fuel variance, along with the maximum ash and sulfur content, if any.

c. An affidavit stating why the owner is unable to, or has substantial cause to believe that he will be unable to, obtain fuel which would allow compliance with applicable provisions of these regulations.

d. An estimate of the amount of fuel to be conserved.

e. An estimate of the increased air pollutants that might cause violations of the ambient air quality standards.

f. An estimate, with reasons given, of the duration of the shortage of fuel which would allow compliance with applicable provisions of these regulations.

g. Such other information as the executive director may require to make his findings as provided in subdivision B 1 of this section.

3. Notice of public hearings on applications for fuel variances shall be advertised at least 10 days prior to the date of the hearing, in at least one major newspaper of general circulation in the air quality control region in which the affected source is located.

4. Fuel variances may be granted only for individual sources, and not for categories or classes.

5. No fuel variance shall be granted for more than 120 days. Any request for a variance for a period beyond 120 days shall be governed by the provisions of subsection A of this section, except that the board, where appropriate, may require compliance with any of the conditions and requirements herein.

C. Nothing in this section shall be construed to limit, alter or otherwise affect the obligation of any person to comply with any provision of these regulations not specifically affected by this section.

§ 120-02-06. Local ordinances.

A. Establishment/approval.

1. Any local governing body proposing to adopt or amend an ordinance, relating to air pollution shall first obtain the approval of the board as to the provisions of the ordinance or amendment. The board in approving local ordinances will consider, but will not be limited to, the following criteria:

a. The local ordinance shall provide for intergovernmental cooperation and exchange of information.

b. Adequate local resources will be committed to enforcing the proposed local ordinance.

c. The provisions of the local ordinance shall be as strict as state regulations, except as provided for leaf burning in § 10.1-1308 of the Virginia Air Pollution Control Law.

2. Approval of any local ordinance shall be withdrawn if the board determines that the local ordinance is less strict than state regulations, or if the locality fails to enforce the ordinance.

3. If a local ordinance must be amended to conform to an amendment to state regulations, such local amendment will be made within six months.

B. Reports.

Local ordinances shall provide for reporting such information as may be required by the board to fulfill its responsibilities under the Virginia Air Pollution Control Law and the federal Clean Air Act. Such reports shall include, but are not limited to: monitoring data, surveillance programs, procedures for investigation of complaints, variance hearings and status of control programs and permits.

C. Relationship to state regulations.

Local ordinances are a supplement to state regulations. Any provisions of local ordinances which have been approved by the board and are more strict than state regulations shall take precedence over state regulations within the respective locality. It is the intention of the board to coordinate activities among the enforcement officers of the various localities in the enforcement of local ordinances and state regulations. The board will also provide technical and other assistance to local authorities in the development of ambient air quality or emission standards, in the investigation and study of air pollution problems, and in the enforcement of local ordinances and state regulations. The board emphasizes its intention to assist in the local enforcement of local ordinances. If a locality fails to enforce its own ordinance, the board reserves the right to enforce state regulations.

D. Variances.

A local governing body may grant a variance to any provision of its air pollution control ordinance(s) provided that:

1. A public hearing is held prior to granting the variance;

2. The public is notified of the application for a variance by advertisement in at least one major newspaper of general circulation in the affected locality at least 30 days prior to the date of the hearing; and

3. The variance does not permit any owner or other person to take action that would result in a violation of any provision of state regulations unless a variance is granted by the board. The public hearings required for the variances to the local ordinance and state regulations may be conducted jointly as one proceeding.

§ 120-02-07. Circumvention.

A. No owner or other person shall cause or permit the installation or use of any device or any means which, without resulting in reduction in the total amount of air pollutants emitted, conceals or dilutes an emission of air pollutants which would otherwise violate these regulations. Such concealment includes, but is not limited to, either of the following:

1. The use of gaseous diluents to achieve compliance with a visible emissions standard or with a standard which is based on the concentration of a pollutant in the gases discharged to the atmosphere.

2. The piecemeal carrying out of an operation to avoid coverage by a standard that applies only to operations larger than a specified size.

B. This section does not prohibit the construction of a stack.

§ 120-02-08. Relationship of state regulations to federal regulations.

A. In order for the Commonwealth to fulfill its obligations under the federal Clean Air Act, some provisions of these regulations are required to be approved by the U.S. Environmental Protection Agency and when approved those provisions become federally enforceable.

B. In cases where these regulations specify that procedures or methods shall be approved by, acceptable to or determined by the board or other similar phrasing or specifically provide for decisions to be made by the board or department, it may be necessary to have such actions (approvals, determinations, exemptions, exclusions, or decisions) reviewed and confirmed as acceptable or approved by the U.S. Environmental Protection Agency in order to make them federally enforceable. Determination of which state actions require federal confirmation or approval and the administrative mechanism for making associated confirmation or approval decisions shall be made on a case-by-case basis in accordance with U.S. Environmental Protection Agency regulations and policy.

§ 120-02-09. Appeals.

A. Any owner or other person aggrieved by any action of the board taken without a formal hearing, or by inaction of the board, may demand a formal hearing in accordance with § 9-6.14:12 of the Administrative Process Act, provided a petition requesting such hearing is filed with the board. In cases involving actions of the board, such petition shall be filed within 30 days after notice of such action is mailed or delivered to such owner or other person.

B. Prior to any formal hearing, the board shall, provided all parties consent, ascertain the fact basis for its decision in accordance with § 9-6.14:11 of the Administrative Process Act.

C. Any decision of the board resultant from a formal hearing shall constitute the final decision of the board.

D. Any owner or other person aggrieved by a final decision of the board may appeal such decision in accordance with § 10.1-1318 of the Virginia Air Pollution Control Law and § 9-6.14:16 of the Administrative Process Act. Any petition for appeal shall be filled within 30 days after the date of such final decision.

E. Nothing in this section shall prevent disposition of any case by consent.

F. Any petition for a formal hearing or for an appeal by itself shall not constitute a stay of decision or action.

§ 120-02-10. Right of entry.

Whenever it is necessary for the purposes of these regulations, the board may at reasonable times enter any establishment or upon any property, public or private, for the purpose of obtaining information or conducting surveys or investigation as authorized by § 10.1-1315 of the Virginia Air Pollution Control Law.

§ 120-02-11. Conditions on approvals.

A. The board may impose conditions upon permits and other approvals which may be necessary to carry out the policy of the Virginia Air Pollution Control Law, and which are consistent with these regulations. Except as specified herein, nothing in these regulations shall be understood to limit the power of the board in this regard. If the owner or other person fails to adhere to such conditions, the board may automatically cancel such permit or approvals. Without limiting the generality of this section, this section shall apply to: approval of variances, approval of control programs, granting of new or modified source permits and granting of open burning permits.

B. An owner may consider any condition imposed by the board as a denial of the requested approval or permit, which shall entitle the applicant to appeal the decision of the board pursuant to § 120-02-09.

§ 120-02-12. Procedural information and guidance.

A. The board may adopt detailed procedures which:

1. Require data and information in addition to and in amplification of the provisions of these regulations;

2. Are reasonably designed to determine compliance with applicable provisions of these regulations; and

3. Set forth the format by which all data and information shall be submitted.

B. In cases where these regulations specify that procedures or methods shall be approved by, acceptable to or determined by the board or other similar phrasing, the owner may request information and guidance concerning the proper procedures and methods and the board shall furnish in writing such information on a case-by-case basis.

§ 120-02-13. Delegation of authority.

In accordance with the Virginia Air Pollution Control Law and the Administrative Process Act, the board confers upon the executive director such administrative, enforcement and decision making powers as are set forth in Appendix F.

§ 120-02-14. Considerations for approval actions.

Pursuant to the provisions of § 10.1-1307 E of the Virginia Air Pollution Control Law, the board, in making regulations and in approving variances, control programs, or permits, shall consider facts and circumstances relevant to the reasonableness of the activity involved and the regulations proposed to control it, including:

A. The character and degree of injury to, or interference with safety, health or the reasonable use of property which is caused or threatened to be caused;

B. The social and economic value of the activity involved;

C. The suitability of the activity to the area in which it is located; and

D. The scientific and economic practicality of reducing or eliminating the discharge resulting from such activity.

§§ 120-02-15 through 120-02-29. Reserved.

§ 120-02-30. Availability of information.

A. Emission data provided to, or otherwise obtained by, the board in accordance with the provisions of these regulations shall be available to the public.

B. Except as provided in subsection A of this section, any records, reports or information provided to, or otherwise obtained by, the board in accordance with provisions of these regulations shall be available to the public, except that:

1. Upon a showing satisfactory to the board by any owner that such records or information, or particular part thereof (other than emission data), if made public, would divulge methods or processes entitled to protection as trade secrets of such owner, the board shall consider such records, reports or information, or particular part thereof, confidential in accordance with the purposes of § 10.1-1314 of the Virginia Air Pollution Control Law except that such records, reports or information, or particular part thereof, may be disclosed to other officers, employees or authorized representatives of the Commonwealth of Virginia and the U.S. Environmental Protection Agency concerned with carrying out the provisions of the Virginia Air Pollution Control Law and the federal Clean Air Act; and

2. Information received by the board in accordance with § 120-02-31, § 120-02-32, Part VII and Part VIII of these regulations shall not be disclosed if it is identified by the owner as being a trade secret or commercial or financial information which such owner considers confidential.

§ 120-02-31. Registration.

A. The owner of any stationary source to which permits are issued under Part VIII or for which emission standards are given in Parts IV, V or VI shall, upon request of the board, register such source operations with the board and update such registration information. The information required for registration shall be determined by the board and shall be provided in the manner specified by the board. Owners should review the emission standard for their respective source type to identify the exemption levels for purposes of this section.

B. The owner of any stationary source emitting 25 tons per year or more of volatile organic compounds or nitrogen oxides and located in any emissions control area designated in Appendix P shall submit an emissions statement to the board by April 15 of each year, beginning in 1993, for the emissions discharged during the previous calendar year. Emissions statements shall be prepared and submitted in accordance with the applicable procedure in Appendix S.

§ 120-02-32. Control programs.

A. Under the provisions of § 120-02-03 A, the board may require an owner of a stationary source to submit a control program, in a form and manner satisfactory to the board, showing how compliance shall be achieved as quickly as possible.

B. The board shall act within 90 days of receiving an acceptable control program. A public hearing will be held within this period. The hearing shall be held only after reasonable notice, at least 30 days prior to the hearing date, which shall include:

1. Notice given to the public by advertisement in at least one major newspaper of general circulation in the affected air quality control region;

2. Availability of the information in the control program (exclusive of confidential information under the provisions of § 120-02-30) for public inspection in at least one location in the affected air quality control region; and

3. Notification to all local air pollution control agencies having State Implementation Plan responsibilities in the affected air quality control region, all states sharing the affected air quality control region, and the regional administrator of the U.S. Environmental Protection Agency.

C. When acting upon control programs, the board shall be guided by the provisions of the federal Clean Air Act.

D. The board may require owners submitting a control program to submit periodic progress reports in the form and manner acceptable to the board.

E. The board normally will take action on all control programs within 30 days after the date of the public hearing unless more information is required. The board shall notify the applicant in writing of its decision on the control program and shall set forth its reasons therefor.

F. The owner may appeal the decision pursuant to § 120-02-09.

§ 120-02-33. Reserved.

§ 120-02-34. Facility and control equipment maintenance or malfunction.

A. At all times, including periods of startup, shutdown and malfunction, owners shall, to the extent practicable, maintain and operate any affected facility, including associated air pollution control equipment or monitoring equipment, in a manner consistent with good air pollution control practice of minimizing emissions.

B. In case of shutdown or bypassing, or both, of air pollution control equipment for necessary scheduled maintenance which results in excess emissions for more than one hour, the intent to shut down such equipment shall be reported to the board and local air pollution control agency, if any, at least 24 hours prior to the planned shutdown. Such prior notice shall include, but is not limited to, the following:

1. Identification of the specific facility to be taken out of service as well as its location and permit or registration number.

2. The expected length of time that the air pollution control equipment will be out of service.

3. The nature and quantity of emissions of air pollutants likely to occur during the shutdown period.

4. Measures that will be taken to minimize the length of the shutdown or to negate the effect of the outage of the air pollution control equipment.

C. In the event that any affected facility or related air pollution control equipment fails or malfunctions in such a manner that may cause excess emissions for more than one hour, the owner shall, as soon as practicable but no later than four daytime business hours, notify the board by facsimile transmission, telephone or telegraph of such failure or malfunction and shall within two weeks provide a written statement giving all pertinent facts, including the estimated duration of the breakdown. Owners subject to the requirements of §§ 120-04-05 C and 120-05-05 C are not required to provide the written statement prescribed in this paragraph for facilities subject to the monitoring requirements of §§ 120-04-04 and 120-05-04. When the condition causing the failure or malfunction has been corrected and the equipment is again in operation, the owner shall notify the board.

D. In the event that the breakdown period cited in subsection C of this section exists or is expected to exist for 30 days or more, the owner shall, within 30 days of the failure or malfunction and semi-monthly thereafter until the failure or malfunction is corrected, submit to the board a written report containing the following:

1. Identification of the specific facility that is affected as well as its location and permit or registration number.

2. The expected length of time that the air pollution control equipment will be out of service.

3. The nature and quantity of air pollutant emissions likely to occur during the breakdown period.

4. Measures to be taken to reduce emissions to the lowest amount practicable during the breakdown period.

5. A statement as to why the owner was unable to obtain repair parts or perform repairs which would allow compliance with the provisions of these regulations within 30 days of the malfunction or failure.

6. An estimate, with reasons given, of the duration of the shortage of repairs or repair parts which would allow compliance with the provisions of these regulations.

7. Any other pertinent information as may be requested by the board.

E. The procedural requirements of subsection D of this section shall not apply beyond three months of the date of the malfunction or failure. Should the breakdown period exist past the three-month period, the owner may apply for a variance in accordance with § 120-02-05 A.

F. The following special provisions govern facilities which are subject to the provisions of Rule 4-3, Rule 5-3 or Rule 6-1:

1. Nothing in this section shall be understood to allow any such facility to operate in violation of applicable emission standards, except that all such facilities shall be subject to the reporting and notification procedures in this section.

2. Any facility which is subject to the provisions of Rule 6-1 shall shut down immediately if it is unable to meet the applicable emission standards, and it shall not return to operation until it is able to operate in compliance with the applicable emission standards.

3. Regardless of any other provision of this section, any facility which is subject to the provisions of Rule 4-3 or 5-3 shall shut down immediately upon request of the board if its emissions increase in any amount because of a bypass, malfunction, shutdown or failure of the facility or its associated air pollution control equipment; and such facility shall not return to operation until it and the associated air pollution control equipment are able to operate in a proper manner.

G. No violation of applicable emission standards or monitoring requirements shall be judged to have taken place if the excess emissions or cessation of monitoring activities is due to a malfunction, provided that:

1. The procedural requirements of this section are met or the owner has submitted an acceptable application for a variance, which is subsequently granted;

2. The owner has taken expedient and reasonable measures to minimize emissions during the breakdown period;

3. The owner has taken expedient and reasonable measures to correct the malfunction and return the facility to a normal operation; and

4. The source is in compliance at least 90% of the operating time over the most recent 12-month period.

H. Nothing in this section shall be construed as giving an owner the right to increase temporarily the emission of pollutants or to circumvent the emission standards or monitoring requirements otherwise provided in these regulations.

I. Regardless of any other provision of this section, the owner of any facility subject to the provisions of these regulations shall, upon request of the board, reduce the level of operation at the facility if the board determines

that this is necessary to prevent a violation of any primary ambient air quality standard. Under worst case conditions, the board may order that the owner shut down the facility, if there is no other method of operation to avoid a violation of the primary ambient air quality standard. The board reserves the right to prescribe the method of determining if a facility will cause such a violation. In such cases, the facility shall not be returned to operation until it and the associated air pollution control equipment are able to operate without violation of any primary ambient air quality standard.

J. Any owner of an affected facility subject to the provisions of this section shall maintain records of the occurrence and duration of any bypass, malfunction, shutdown or failure of the facility or its associated air pollution control equipment that results in excess emissions for more than one hour. The records shall be maintained in a form suitable for inspection and maintained for at least two years following the date of the occurrence.

PART IV.
EMISSION STANDARDS FOR GENERAL PROCESS OPERATIONS.
(RULE 4-4)

§ 120-04-0401. Applicability and designation of affected facility.

A. Except as provided in subsections C and D of this section, the affected facility to which the provisions of this rule apply is each process operation, each process gas stream and each combustion installation.

B. The provisions of this rule apply throughout the Commonwealth of Virginia.

C. Exempted from the provisions of this rule are the following:

1. Process operations with a process weight rate capacity less than 100 pounds per hour.

2. Any combustion unit using solid fuel with a maximum heat input of less than 350,000 Btu per hour.

3. Any combustion unit using liquid fuel with a maximum heat input of less than 1,000,000 Btu per hour.

4. Any combustion unit equipment unit using gaseous fuel with a maximum heat input of less than 10,000,000 Btu per hour.

D. The provisions of this rule do not apply to affected facilities subject to other emission standards in this part.

§ 120-04-0402. Definitions.

A. For the purpose of these regulations and subsequent amendments or any orders issued by the board, the words or terms shall have the meaning given them in subsection C of this section.

B. As used in this rule, all terms not defined herein shall have the meaning given them in Part I, unless otherwise required by context.

C. Terms defined.

"Combustion installation" means all combustion units within a stationary source in operation prior to October 5, 1979.

"Combustion unit" means any type of stationary equipment in which solid, liquid or gaseous fuels and refuse are burned, including, but not limited to, furnaces, ovens, and kilns.

"Heat input" means the total gross calorific value of all fuels burned.

"Manufacturing operation" means any process operation or combination of physically connected dissimilar process operations which is operated to effect physical or chemical changes or both in an article.

"Materials handling equipment" means any equipment used as a part of a process operation or combination of process operations which does not effect a physical or chemical change in the material or in an article, such as, but not limited to, conveyors, elevators, feeders or weighers.

"Physically connected" means any combination of process operations connected by materials handling equipment and designed for simultaneous complementary operation.

"Process operation" means any method, form, action, operation or treatment of manufacturing or processing, including any storage or handling of materials or products before, during or after manufacturing or processing.

"Process unit" means any step in a manufacturing or process operation which results in the emission of pollutants to the atmosphere.

"Process weight" means total weight of all materials introduced into any process unit which may cause any emission of pollutants. Process weight includes solid fuels charged, but does not include liquid and gaseous fuels charged or combustion air for all fuels.

"Process weight rate" means a rate established as follows:

a. For continuous or long-run steady-state process operations, the total process weight for the entire period of continuous operation or for a typical portion thereof, divided by the number of hours of

such period or portion thereof.

b. For cyclical or batch process operations, the total weight for a period that covers a complete operation or an integral number of cycles, divided by the hours of actual process operation during such a period.

"Reasonably available control technology" means the lowest emission limit that a particular source is capable of meeting by the application of control technology that is reasonably available, considering technological and economic feasibility.

"Rated capacity" means, the capacity as stipulated in the purchase contract for the condition of 100% load, or such other capacities as mutually agreed to by the board and owner using good engineering judgment.

"Total capacity" means with reference to a combustion installation, the sum of the rated capacities (expressed as heat input) of all units of the installation which must be operated simultaneously under conditions or 100% use load.

§ 120-04-0403. Standard for particulate matter (AQCR 1-6).

A. No owner or other person shall cause or permit to be discharged into the atmosphere from any process unit any particulate emissions in excess of the limits in Table 4-4A.

TABLE 4-4A

Process Lb/Hr	Weight Rate Tons/Hr	Maximum Allowable Emission Rate Lb/Hr
100	0.05	0.551
200	0.10	0.877
400	0.20	1.40
600	0.30	1.83
800	0.40	2.22
1000	0.50	2.58
1500	0.75	3.38
2000	1.00	4.10
2500	1.25	4.76
3000	1.50	5.38
3500	1.75	5.96
4000	2.00	6.52
5000	2.50	7.58
6000	3.00	8.56
7000	3.50	9.49
8000	4.00	10.4
9000	4.50	11.2
10000	5.00	12.0
12000	6.00	13.6
16000	8.00	16.5
18000	9.00	17.9
20000	10.00	19.2
30000	15.00	25.2
40000	20.00	30.5
50000	25.00	35.4
60000	30.00	40.0
70000	35.00	41.3
80000	40.00	42.5
90000	45.00	43.6
100000	50.00	44.6
120000	60.00	46.3
140000	70.00	47.8
160000	80.00	49.1
200000	100.00	51.3
1000000	500.00	69.0
2000000	1000.00	77.6
6000000	3000.00	92.7

B. Except as provided in subsections C and D of this section, interpretation of the emission standard in subsection A of this section shall be in accordance with Appendix Q.

C. Interpolation of the data in Table 4-4A for process weight rates up to 60,000 lb/hr shall be accomplished by use of the following equation:

$$E = 4.10\ P0.67$$

where:

E = emission rate in lb/hr.

P = process weight rate in tons/hr.

D. Interpolation and extrapolation of the data for process weight rates in excess of 60,000 lb/hr shall be accomplished by use of the following equation:

E = 55.0 P0.11 - 40

where:

E = emission rate in lb/hr.

P = process weight rate in tons/hr.

§ 120-04-0404. Standard for particulate matter (AQCR 7).

A. No owner or other person shall cause or permit to be discharged into the atmosphere from any process unit any particulate emissions in excess of the limits in Table 4-4B.

TABLE 4-4B

Process Weight Rate Lb/Hr	Tons/Hr	Maximum Allowable Emission Rate L b/Hr
100	0.050	0.46
150	0.075	0.66
200	0.100	0.85
250	0.125	1.03
300	0.150	1.20
350	0.175	1.35
400	0.200	1.50
450	0.225	1.63
500	0.250	1.77
550	0.275	1.85
600	0.300	2.01
650	0.325	2.12
700	0.350	2.24
750	0.375	2.34
800	0.400	2.43
850	0.425	2.53
900	0.450	2.62
950	0.475	2.72
1000	0.500	2.80
1100	0.55	2.97
1200	0.60	3.12
1300	0.65	3.26
1400	0.70	3.40
1500	0.75	3.54
1600	0.80	3.66
1700	0.85	3.79
1800	0.90	3.91
1900	0.95	4.03
2000	1.00	4.14
2100	1.05	4.24
2200	1.10	4.34
2300	1.15	4.44
2400	1.20	4.55
2500	1.25	4.64
2600	1.30	4.74
2700	1.35	4.84
2800	1.40	4.92
2900	1.45	5.02
3000	1.50	5.10
3100	1.55	5.18
3200	1.60	5.27
3300	1.65	5.36
3400	1.70	5.44
3500	1.75	5.52
3600	1.80	5.61
3700	1.85	5.69

3800	1.90	5.77
3900	1.95	5.85
4000	2.00	5.93
4100	2.05	6.01
4200	2.10	6.08
4300	2.15	6.15
4400	2.20	6.22
4500	2.25	6.30
4600	2.30	6.37
4700	2.35	6.45
4800	2.40	6.52
4900	2.45	6.60
5000	2.50	6.67
5500	2.75	7.03
6000	3.00	7.37
6500	3.25	7.71
7000	3.50	8.05
7500	3.75	8.39
8000	4.00	8.71
8500	4.25	9.03
9000	4.50	9.36
9500	4.75	9.67
10000	5.00	10.00
11000	5.50	10.63
12000	6.00	11.28
13000	6.50	11.89
14000	7.00	12.50
15000	7.50	13.13
16000	8.00	13.74
17000	8.50	14.36
18000	9.00	14.97
19000	9.50	15.58
20000	10.00	16.19
30000	15.00	22.22
40000	20.00	28.30
50000	25.00	34.30
60000 or more	30.00 or more	40.00

B. Interpretation of the emission standard in subsection A of this section shall be in accordance with Appendix Q.

§ 120-04-0405. Standard for sulfur dioxide.

A. Noncombustion process operations.

No owner or other person shall cause or permit to be discharged into the atmosphere from any process operation any sulfur dioxide emissions in excess of an in-stack concentration of 2000 ppm by volume.

B. Combustion installations.

1. No owner or other person shall cause or permit to be discharged into the atmosphere from any combustion installation any sulfur dioxide emissions in excess of the following limits:

a. $S = 2.64K$ (AQCR 1 through 6)

b. $S = 1.06K$ (for liquid or gaseous fuels - AQCR 7)

c. $S = 1.52K$ (for solid fuels - AQCR 7)

where:

S = allowable emission of sulfur dioxide

expressed in lbs/hr.

K = actual heat input at total capacity expressed in Btu x 10^6 per hour.

2. Where there is more than one unit in a combustion installation and where the installation can be shown, to the satisfaction of the board, to be in compliance when the installation is operating at total capacity, the installation will be deemed to still be in compliance when the installation is operated at reduced load or one or more units are shut down for maintenance or repair, provided that the same type of fuel with the same sulfur content, or an equivalent, is continued in use.

3. For installations in AQCR 7 at which different fossil fuels are burned simultaneously, whether in the same or different units, the allowable emissions shall be determined by proration using the following formula:

$$PS = K \frac{X(1.06) + Y(1.52)}{X + Y}$$

where:

PS = prorated allowable emissions of sulfur dioxide expressed in lb/hr.

X = percentage of actual heat input at total capacity derived from liquid or gaseous fuel.

Y = percentage of actual heat input at total capacity derived from solid fuels.

K = actual heat input at total capacity expressed in Btu x 10^6 per hour.

§ 120-04-0406. Standard for hydrogen sulfide.

No owner or other person shall cause or permit to be discharged into the atmosphere from any process gas stream any hydrogen sulfide emissions in excess of a concentration greater than 15 grains per 100 cubic feet of gas without burning or removing H2S in excess of this concentration, provided that SO2 emissions in the burning operation meet the requirements of § 120-04-0405 A.

§ 120-04-0407. Standard for volatile organic compounds.

A. No owner or other person shall cause or permit to be discharged from any affected facility any *volatile organic compound* emissions in excess of that resultant from using reasonably available control technology.

B. The provisions of this section apply to all facilities that (i) are within a stationary source in the Northern Virginia ~~(AQCR 7) and~~ *or* Richmond ~~(AQCR 5) Nonattainment Areas (see Appendix K)~~ *Emissions Control Area (see Appendix P)* and (ii) have a theoretical potential to emit ~~sum total~~ of *50 tons per year or greater in the Northern Virginia Emissions Control Area or* 100 tons per year or greater *in the Richmond Emissions Control Area* . Theoretical potential to emit shall be based on emissions at design capacity or maximum production and maximum operating hours (8,760 hours/year) before add-on controls, unless the facility is subject to state and federally enforceable permit conditions which limit production rates or hours of operation. Emissions from all facilities, including facilities exempt from any other emission standard for volatile organic compounds in Part IV, shall be added together to determine theoretical potential to emit.

C. For facilities subject to the provisions of this section, the owners shall within three months of the effective date of this emission standard *(i)* notify the board of their ~~eligibility~~ *applicability* status, *(ii)* commit to making a determination as to what constitutes reasonably available control technology for the facilities and *(iii)* provide a schedule acceptable to the board for making this determination *and for achieving compliance with the emission standard as expeditiously as possible but not later than May 31, 1995* .

D. Any emission limits or other requirements necessary to define and enforce reasonably available control technology for applicable source types under this section shall be made state enforceable by a permit issued under Part VIII of these regulations.

§ 120-04-0408. Standard for nitrogen oxides.

A. No owner or other person shall cause or permit to be discharged from any affected facility any nitrogen oxides emissions in excess of that resultant from using reasonably available control technology.

B. Unless the owner demonstrates otherwise to the satisfaction of the board, reasonably available control technology as defined in Appendix T for the applicable source types is required to comply with the provisions of subsection A of this section.

C. The provisions of this section apply to all facilities that (i) are within a stationary source in the Northern Virginia or Richmond Emissions Control Area (see Appendix P) and (ii) have a theoretical potential to emit of 50 tons per year or greater in the Northern Virginia Emissions Control Area or 100 tons per year or greater in the Richmond Emissions Control Area. Theoretical potential to emit shall be based on emissions at design capacity or maximum production and maximum operating hours (8,760 hours/year) before add-on controls, unless the facility is subject to state and federally enforceable permit conditions which limit production rates or hours of operation. Emissions from all facilities, including facilities exempt from any other emission standard for nitrogen oxides in Part IV, shall be added together to determine theoretical potential to emit.

D. For facilities subject to the provisions of subsection A of this section, the owners shall within three months of the effective date of the emission standard (i) notify the board of their applicability status, (ii) commit to making a determination as to what constitutes reasonably available control technology for the facilities and (iii) provide a schedule acceptable to the board for making this determination and achieving compliance with the emission standard as expeditiously as possible but no later than May 31, 1995.

E. For facilities to which the provisions of subsection B of this section are applicable, the owners shall within three months of the effective date of the emission standard (i) notify the board of their applicability status, (ii) commit to accepting the emission standard as reasonably available control technology for the applicable facilities or submit a demonstration as provided in subsection B of this section and (iii) provide a schedule acceptable to the board for achieving compliance with the emission standard as expeditiously as possible but no later

than May 31, 1995.

F. Any emission limits or other requirements necessary to define and enforce reasonably available control technology for applicable source types under this section shall be made state enforceable by a permit issued under Part VIII of these regulations.

~~§ 120-04-0408.~~ *§ 120-04-0409.* Standard for visible emissions.

The provisions of Rule 4-1 (Emission standards for visible emissions and fugitive dust/emissions) apply.

~~§ 120-04-0409.~~ *§ 120-04-0410.* Standard for fugitive dust/emissions

The provisions of Rule 4-1 (Emission standards for visible emissions and fugitive dust/emissions) apply.

~~§ 120-04-0410.~~ *§ 120-04-0411.* Standard for odor.

The provisions of Rule 4-2 (Emission standards for odor) apply.

~~§ 120-04-0411.~~ *§ 120-04-0412.* Standard for noncriteria pollutants.

The provisions of Rule 4-3 (Emission standards for noncriteria pollutants) apply.

~~§ 120-04-0412.~~ *§ 120-04-0413.* Compliance.

The provisions of § 120-04-02 (Compliance) apply.

~~§ 120-04-0413.~~ *§ 120-04-0414.* Test methods and procedures.

The provisions of § 120-04-03 (Emission testing) apply.

~~§ 120-04-0414.~~ *§ 120-04-0415.* Monitoring.

The provisions of § 120-04-04 (Monitoring) apply.

~~§ 120-04-0415.~~ *§ 120-04-0416.* Notification, records and reporting.

The provisions of § 120-04-05 (Notification, records and reporting) apply.

~~§ 120-04-0416.~~ *§ 120-04-0417.* Registration.

The provisions of § 120-02-31 (Registration) apply.

~~§ 120-04-0417.~~ *§ 120-04-0418.* Facility and control equipment maintenance or malfunction.

The provisions of § 120-02-34 (Facility and control equipment maintenance or malfunction) apply.

~~§ 120-04-0418.~~ *§ 120-04-0419.* Permits.

A permit may be required prior to beginning any of the activities specified below and the provisions of Part V (New and Modified Sources) and Part VIII (Permits for New and Modified Sources) may apply. Owners contemplating such action should contact the appropriate regional office for guidance.

A. Construction of a facility.

B. Reconstruction (replacement of more than half) of a facility.

C. Modification (any physical change to equipment) of a facility.

D. Relocation of a facility.

E. Reactivation (restart-up) of a facility.

APPENDIX P.
VOLATILE ORGANIC COMPOUND *AND NITROGEN OXIDES* EMISSIONS CONTROL AREAS.

~~Volatile Organic Compound Emissions Control Areas are geographically defined as follows:~~

~~Air Quality Control Region 1~~	~~None~~
~~Air Quality Control Region 2~~	~~None~~
~~Air Quality Control Region 3~~	~~None~~
~~Air Quality Control Region 4~~	~~Stafford County~~
~~Air Quality Control Region 5~~	~~Richmond City~~ ~~Chesterfield County~~ ~~Henrico County~~
~~Air Quality Control Region 6~~	~~Chesapeake City~~ ~~Hampton City~~ ~~Newport News City~~ ~~Norfolk City~~ ~~Portsmouth City~~ ~~Suffolk City~~ ~~Virginia Beach City~~
~~Air Quality Control Region 7~~	~~Alexandria City~~ ~~Fairfax City~~ ~~Falls Church City~~ ~~Manassas City~~ ~~Manassas Park City~~ ~~Arlington County~~ ~~Fairfax County~~ ~~Loudoun County~~ ~~Prince William County~~

Emissions Control Areas are geographically defined below by locality for the pollutants indicated.

A. Volatile Organic Compounds.

1. Northern Virginia Emissions Control Area.

Arlington County	*Alexandria City*
Fairfax County	*Fairfax City*

Loudoun County	*Falls Church City*
Prince William County	*Manassas City*
Stafford County	*Manassas Park City*

2. Richmond Emissions Control Area.

Charles City County	*Colonial Heights City*
Chesterfield County	*Hopewell City*
Hanover County	*Richmond City*
Henrico County	

3. Hampton Roads Emissions Control Area.

Chesapeake City	*Portsmouth City*
Hampton City	*Suffolk City*
Newport News City	*Virginia Beach City*
Norfolk City	

B. Nitrogen Oxides.

1. Northern Virginia Emissions Control Area.

Arlington County	*Alexandria City*
Fairfax County	*Fairfax City*
Loudoun County	*Falls Church City*
Prince William County	*Manassas City*
Stafford County	*Manassas Park City*

2. Richmond Emissions Control Area.

Charles City County	*Colonial Heights City*
Chesterfield County	*Hopewell City*
Hanover County	*Richmond City*
Henrico County	

3. Hampton Roads Emissions Control Area.

Chesapeake City	*Portsmouth City*
Hampton City	*Suffolk City*
Newport News City	*Virginia Beach City*
Norfolk City	

APPENDIX S.
AIR QUALITY PROGRAM POLICIES AND PROCEDURES.

I. General.

A. In order for the Commonwealth to fulfill its obligations under the federal Clean Air Act, some provisions of these regulations are required to be approved by the U.S. Environmental Protection Agency as part of the State Implementation Plan, and when approved, those provisions become federally enforceable.

B. In cases where these regulations specify that procedures or methods shall be approved by, acceptable to or determined by the board or other similar phrasing or specifically provide for decisions to be made by the board or department, it may also be necessary to have such actions (approvals, determinations, exemptions, exclusions, or decisions) approved by the U.S. Environmental Protection Agency as part of the State Implementation Plan in order to make them federally enforceable. In accordance with U.S. Environmental Protection Agency regulations and policy, it has been determined that it is necessary for the procedures listed in Section II of this appendix to be approved as part of the State Implementation Plan.

C. Failure to include in this appendix any procedure mentioned in the regulations shall not invalidate the applicability of the procedure.

D. Copies of materials listed in this appendix may be examined by the public at the headquarters office of the Department of Air Pollution Control, Eighth Floor, Ninth Street Office Building, 200-202 North Ninth Street, Richmond, Virginia, between 8:30 a.m. and 4:30 p.m. of each business day.

II. Specific documents.

A. Procedures for Testing Facilities Subject to Emission Standards for Volatile Organic Compounds, AQP-1, July 1, 1991.

B. Procedures for Determining Compliance with Volatile Organic Compound Emission Standards Covering Surface Coating Operations, AQP-2, July 1, 1991.

C. Procedures for the Measurement of Capture Efficiency for Determining Compliance with Volatile Organic Compound Emission Standards Covering Surface Coating Operations, AQP-3, July 1, 1991.

D. Procedures for Maintaining Records for Surface Coating Operations and Graphic Arts Printing Processes, AQP-4, July 1, 1991.

E. Procedures for Preparing and Submitting Emission Statements for Stationary Sources, AQP-8, January 1, 1993.

APPENDIX T.
REASONABLY AVAILABLE CONTROL TECHNOLOGY GUIDELINES FOR STATIONARY SOURCES OF NITROGEN OXIDES.

I. General.

A. Unless otherwise approved by the board, this appendix defines reasonably available control technology for the purposes of compliance with § 120-04-0408 A for the source types specified herein.

B. Any emission limits or other requirements necessary to define reasonably available control technology for applicable source types under this appendix shall be made state enforceable by a permit issued under Part VIII of these regulations.

II. Definitions.

A. For the purpose of these regulations and subsequent amendments of any orders issued by the board, the words

or terms shall have the meaning given them in subsection C of this section.

B. As used in this appendix, all terms not defined herein shall have the meaning given them in Part I, unless otherwise required by context.

C. Terms defined.

"Capacity factor" means the ratio of the average load on a machine or equipment for the period of time considered to the capacity rating of the machine or equipment.

Combustion modification" means any change to the configuration of the burners or the firing method or mechanism of any combustion equipment for the purpose of reducing the emissions of nitrogen oxides. This term includes, but is not limited to, reburning, burners out of service, flue gas recirculation, fuel substitution, and the addition of over fire air and low nitrogen oxides burner systems.

"Combustion unit" means any furnace, with fuel burning equipment appurtenances thereto, used in the process of burning fuel for the primary purpose of producing heat to be utilized by direct heat transfer. This includes, but is not limited to, the following facilities: drying ovens, burnout ovens, annealing furnaces, melting furnaces, holding furnaces, and space heaters.

"Fossil fuel" means natural gas, petroleum, coal and any form of solid, liquid or gaseous fuel derived from such materials for the purpose of creating useful heat.

"Fuel burning equipment" means any furnace, with fuel burning equipment appurtenances thereto, used in the process of burning fuel for the primary purpose of producing heat to be utilized by indirect heat transfer or producing power. This includes facilities that are designed as boilers to produce steam or heated water and are designed to burn either fossil fuel or refuse derived fuel. It does not include such facilities if designed primarily to burn raw refuse.

"Fuel burning equipment installation" means all fuel burning equipment units within a stationary source in operation prior to January 1, 1993.

"Gas turbine" means a rotary internal combustion engine fueled by liquid or gaseous fuel.

"Heat input" means the total gross calorific value of all fuels burned.

"Incinerator" means any device, apparatus, equipment, or structure using combustion or pyrolysis for destroying, or reducing the volume of any material or substance.

"Internal combustion engine" means a reciprocating engine which is fueled by liquid or gaseous fuel.

"Process heater" means any fuel burning equipment which is used to produce heat for use in a manufacturing process. This term includes boilers which use a heat transfer medium other than water, but does not include drying ovens, steam generating units, or other drying apparatus.

"Rated capacity" means the capacity as stipulated in the purchase contract for the condition of 100% load, or such other capacities as mutually agreed to by the board and owner using good engineering judgment.

"Refuse derived fuel (RDF)" means fuel produced from solid or liquid waste (includes materials customarily referred to as refuse and other discarded materials) which has been segregated and classified, with the useable portions being put through a size reduction and classification process which results in a relatively homogeneous mixture.

"Steam generating unit" means any furnace, boiler or other device used for combusting fuel for the purpose of producing steam.

"Total capacity" means, with reference to a fuel burning equipment installation, the sum of the rated capacities (expressed as heat input) of all units of the installation which must be operated simultaneously under conditions of 100% use load.

III. Definition of reasonably available control technology.

A. For the source types listed below, reasonably available control technology is defined as the emission limits specified below based upon the application of combustion modification; however, owners may elect to use any alternative control technology, provided such alternative is capable of achieving the prescribed emission limits.

1. Steam generating units and process heaters.

TABLE T-1
Maximum Allowable Emission Rates for Nitrogen Oxides Emissions from Steam Generating Units and Process Heaters (pounds per million BTU heat input)

Fuel Type	Firing Method		
	Face* and Tangential	Cyclone	Stokers
Coal – wet bottom	1.0	.55	N/A
Coal – dry bottom	.38	N/A	0.4
Oil or Gas or both	.25	.43	N/A
Gas only	.20	N/A	N/A

** Includes wall, opposed and vertical firing methods.*

2. Gas turbines. The maximum allowable emission rate for nitrogen oxides from gas turbines is as follows:

TABLE T-2
Maximum Allowable Emission Rates for Nitrogen Oxides Emissions from Gas Turbines (parts per million by dry volume corrected to 15% oxygen)

Fuel Type	Turbine Type	
	Simple Cycle	Combined Cycle
Gas	42	42
Oil	65/77*	65/77*

** Limit shall be 65 ppm for fuel bound nitrogen (FBN) lesser than 0.015% and 77 ppm for FBN greater than or equal to .015%*

B. Any demonstration of compliance with the limits in subsection A of this section must be on a daily basis.

C. For the source types and sizes listed below, a demonstration of reasonably available control technology is not required as provided in § 120-04-0408 B.

1. Any steam generating unit, process heater or gas turbine with a rated capacity of less than 100,000,000 BTUs per hour.

2. Any steam generating unit, process heater or gas turbine with an annual capacity factor of less than 5.0%, except that three months following any calendar year during which the capacity factor is 5.0% or greater, the facility shall be subject to § 120-04-0408 A or B, as applicable, and the owner shall comply with § 120-04-0408 D or E, as applicable, except the compliance date shall be two years after approval of the schedule by the board.

3. Any combustion unit with a rated capacity of less than 50,000,000 BTUs per hour.

4. Any stationary internal combustion engine with a rated capacity of less than 450 hp of output power.

6. Any incinerator or thermal or catalytic oxidizer used exclusively as air pollution control equipment.

IV. Emission allocation system.

A. This section applies only to steam generating units and gas turbines within fuel burning equipment installations not exempted from the requirements of § 120-04-0408 B by Section III C of this appendix.

B. The maximum allowable nitrogen oxides emissions, expressed as pounds per hour, for a fuel burning equipment installation shall be the product of the total capacity and the applicable emission limit specified in Section III A 1.

C. The allowable nitrogen oxides emissions for a fuel burning equipment installation when operating at less than total capacity, shall be the product of the percent load and emission allocation. The percent load shall be the quotient of the actual load and the rated capacity. The emission allocation shall be determined using procedures set forth in subsection D of this section.

D. The emission allocation for each of the fuel burning equipment units of the fuel burning equipment installation shall be its designated portion of the maximum allowable nitrogen oxides emissions from the fuel burning equipment installation when operating at total capacity. The portions shall be proposed by the owner initially and determined in a manner mutally acceptable to the board and the owner. Once accepted by the board, the portions may not be changed without the consent of the board.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF AIR POLLUTION CONTROL

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DOCUMENT CERTIFICATION FORM

(see other side for instructions)

I certify under penalty of law that this document and all attachments were prepared under my direction or supervision in accordance with a system designed to assure that qualified personnel properly gather and evaluate the information submitted. Based on my inquiry of the person or persons who manage the system, or those persons directly responsible for gathering and evaluating the information, the information submitted is, to the best of my knowledge and belief, true, accurate, and complete. I am aware that there are significant penalties for submitting false information, including the possibility of fine and imprisonment for knowing violations.

SIGNATURE: _____ DATE: _____

NAME: _____

TITLE: _____

COMPANY: _____

PHONE: _____

1

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF AIR POLLUTION CONTROL

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DOCUMENT CERTIFICATION FORM

INSTRUCTIONS FOR USE

Various provisions of the Regulations for the Control and Abatement of Air Pollution require that certain documents submitted to the Board or the Department be signed by a responsible official with certification that the information contained in the statement is accurate to the best knowledge of the individual certifying the statement. Documents covered by this requirement include, but are not limited to, permit applications, registrations, emission statements, emission testing and monitoring reports, or compliance certifications. The certification should include the full name, title, signature, date of signature, and telephone number of the responsible official. A responsible official is defined as follows:

1. For a corporation, association or cooperative, a responsible official is either (i) the president, secretary, treasurer, or a vice-president of the corporation in charge of a principal business function, or any other person who performs similar policy or decision-making functions for the corporation, or (ii) a duly authorized representative of such cooperation if the representative is responsible for the overall operation of one or more manufacturing, production, or operating facilities applying for or subject to a permit and either (i) the facilities employ more than 250 persons or have gross annual sales or expenditures exceeding $25 million (in second quarter 1980 dollars), or (ii) the authority to sign documents has been assigned or delegated to such representative in accordance with corporate procedures.

2. For a partnership or sole proprietorship, a responsible official is a general partner or the proprietor, respectively.

3. For a municipality, state, federal, or other public agency, a responsible official is either a principal executive officer or ranking elected official. A principal executive officer of a federal agency includes the chief executive officer having responsibility for the overall operations of a principal geographic unit of the agency.

2

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Title of Regulation: **VR 120-01. Regulations for the Control and Abatement of Air Pollution - Emission Standards for Petroleum Liquid Storage and Transfer Operations.**

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

Public Hearing Date: July 22, 1992 - 10 a.m.
(See Calendar of Events section for additional information)

Summary:

The regulation amendments concern provisions covering emission standards for volatile organic compounds from petroleum liquid storage and transfer operations and are summarized below:

1. Require owners of gasoline dispensing facilities in moderate or worse nonattainment areas (Richmond and Northern Virginia Emissions Control Areas) with an average monthly throughput of more than 10,000 gallons to install and operate a control system for recovery of gasoline vapors emitted during the fueling of motor vehicles. The localities included in the Northern Virginia and Richmond Emissions Control Areas are the same as those in the Northern Virginia and Richmond Nonattainment Areas.

2. Require owners of gasoline dispensing facilities which begin actual construction after January 1, 1993, to install and operate vapor recovery systems upon start-up, unless proven exempt from the Stage II vapor recovery system requirements. Require owners of facilities which begin actual construction after November 15, 1990, and before January 1, 1993, to install and operate vapor recovery systems by May 15, 1993. Require owners of facilities which begin actual construction on or before November 15, 1990, and dispense an average monthly throughput of 100,000 gallons or more of gasoline to install and operate vapor recovery systems by November 15, 1993. Facilities which begin construction on or before November 15, 1990, and dispense an average monthly throughput of less than 100,000 gallons, but more than 10,000 gallons, must install and operate vapor recovery systems by November 15, 1994.

3. Allow an exemption for gasoline dispensing facilities with an average monthly throughput of less than 50,000 gallons that are owned by an independent small business gasoline marketer.

4. Allow an exemption for gasoline dispensing devices which are used exclusively to refuel marine vehicles, aircraft, farm equipment and emergency vehicles.

5. Provide authority for requiring Stage II vapor recovery system operator training, equipment approval, testing, inspection, maintenance and all associated recordkeeping and reporting. Detailed procedures for these requirements are in an air quality program policies and procedures document.

VR 120-01. Regulations for the Control and Abatement of Air Pollution - Emission Standards for Petroleum Liquid Storage and Transfer Operations.

PART IV.
EMISSION STANDARDS FOR PETROLEUM LIQUID STORAGE AND TRANSFER OPERATIONS.
(RULE 4-37)

§ 120-04-3701. Applicability and designation of affected facility.

A. Except as provided in subsection C of this section, the affected facility to which the provisions of this rule apply is each operation involving the storage or transfer of petroleum liquids or both.

B. The provisions of this rule apply to sources of volatile organic compounds in volatile organic compound emissions control areas designated in Appendix P. The provisions of this rule shall apply in localities outside the volatile organic compound emissions control areas according to the following schedule of effective dates:

1. On January 1, 1993, for facilities subject to the emission standards in § 120-04-3703 A, B, and C and associated tank trucks that load at these facilities.

2. On January 1, 1996, for facilities subject to the emission standard in § 120-04-3703 D and associated account trucks that load or unload at these facilities.

3. On January 1, 1999, for facilities subject to the emission standard in § 120-04-3703 E.

C. The provisions of this rule do not apply to affected facilities using petroleum liquids with a vapor pressure less than 1.5 pounds per square inch absolute under actual storage conditions or, in the case of loading or processing, under actual loading or processing conditions. (Kerosene and fuel oil used for household heating have vapor pressures of less than 1.5 pounds per square inch absolute under actual storage conditions; therefore, kerosene and fuel oil are not subject to the provisions of this rule when used or stored at ambient temperatures).

D. The burden of proof of eligibility for exemption from this rule is on the owner. Owners seeking such an exemption shall maintain adequate records of average monthly throughput and furnish these records to the board upon request.

§ 120-04-3702. Definitions.

A. For the purpose of these regulations and subsequent amendments or any orders issued by the board, the word

or terms shall have the meaning given them in subsection C of this section.

B. As used in this rule, all terms not defined herein shall have the meaning given them in Part I, unless otherwise required by context.

C. Terms defined.

"Average monthly throughput" means the average monthly amount of gasoline pumped at a gasoline dispensing facility during the two most recent consecutive calendar years.

"Begin actual construction" means initiation of permanent physical on-site construction of a new gasoline dispensing facility. This includes, but is not limited to, installation of building supports and foundations, laying of underground pipework, and construction of permanent storage structures.

"Bulk gasoline plant" means a secondary distribution point for delivering gasoline to local farms, businesses, service stations and other distribution points, where the total gasoline throughput is 20,000 gallons or less per working day, based on the daily average for the most recent 12-month period.

"Bulk gasoline terminal" means a primary distribution point for delivering gasoline to bulk plants, service stations and other distribution points, where the total gasoline throughput is greater than 20,000 gallons per working day, based on the daily average for the most recent 12-month period.

"Certified Stage II vapor recovery system" means any system certified by California Air Resources Board as having a vapor recovery or removal efficiency of at least 95%, and approved under the provisions of AQP-9, Procedures for Implementation of Regulations Covering Stage II Vapor Recovery Systems for Gasoline Dispensing Facilities (see Appendix S).

"Condensate" means a hydrocarbon liquid separated from natural gas which condenses due to changes in the temperature or pressure or both and remains liquid at standard conditions.

"Crude oil" means a naturally occurring mixture which consists of any combination of hydrocarbons, sulfur, nitrogen or oxygen derivatives of hydrocarbons and which is a liquid at standard conditions.

"Custody transfer" means the transfer of produced crude oil or condensate, after processing or treating or both in the producing operations, from storage tanks or automatic transfer facilities to pipelines or any other forms of transportation.

"Defective equipment" means any absence, disconnection, or malfunctioning of a Stage II vapor recovery system component required by this rule including, but not limited to, the following:

a. A vapor return line that is crimped, flattened, blocked, or that has any hole or slit that allows vapors to leak out.

b. A nozzle bellows that has any hole large enough to allow a 1/4-inch diameter cylindrical rod to pass through it or any slit one inch or more in length.

c. A nozzle faceplate or cone that is torn or missing over 25% of its surface.

d. A nozzle with no automatic overfill control mechanism, or an inoperable overfill control mechanism.

e. An inoperable or malfunctioning vapor processing unit, vacuum generating device, pressure or vacuum relief valve, vapor check valve or any other equipment normally used to dispense gasoline or is required by this rule.

"External floating roof" means a storage vessel cover in an open top consisting of a double deck or pontoon single deck which rests upon and is supported by the liquid being contained and is equipped with a closure seal or seals to close the space between the roof edge and tank shell.

"Gasoline" means any petroleum distillate having a Reid vapor pressure of four pounds per square inch or greater.

"Gasoline dispensing facility" means any site where gasoline is dispensed to motor vehicle tanks from stationary storage tanks.

"Independent small business gasoline marketer" means a person who owns one or more gasoline dispensing facilities who is engaged in the marketing of gasoline, unless such owner:

a. Is a refiner; controls, or is controlled by, or is under common control with, a refiner; or is otherwise directly or indirectly affiliated with a refiner (unless the sole affiliation is by means of a supply contract or an agreement or contract to use a trademark, tradename, service mark, or other identifying symbol or name owned by such refiner or such person); or

b. Receives less than 50% of their annual income from refining or marketing of gasoline.

For the purposes of this definition, "control" of a corporation means ownership of more than 50% of its stock and "control" of a partnership, joint venture or other nonstock entity means ownership of more than a 50% interest in such partnership, joint venture or other nonstock entity.

"Internal floating roof" means a cover or roof in a fixed roof tank which rests upon or is floated upon the liquid being contained and is equipped with a closure seal or seals to close the space between the roof edge and tank shell.

"Liquid-mounted" means a primary seal mounted so the bottom of the seal covers the liquid surface between the tank shell and the floating roof.

"Major system modification" means the replacement, repair or upgrade of 75% of a facility's Stage II vapor recovery system equipment.

"Owner" means, for the purposes of subsections E and F of § 120-04-3703 and § 120-04-3704, any person who owns or operates a gasoline storage and dispensing system.

"Petroleum liquids" means crude oil, condensate, and any finished or intermediate products manufactured or extracted in a petroleum refinery.

"Petroleum refinery" means any facility engaged in producing gasoline, kerosene, distillate fuel oils, residual fuel oils, lubricants or other products through distillation of petroleum or through redistillation, cracking, rearrangement or reforming of unfinished petroleum derivatives.

"Refiner" means any person or entity that owns or operates a facility engaged in the production of gasoline, kerosene, distillate fuel oils, residual fuel oils, lubricants or similar products through distillation of petroleum or through redistillation, cracking, or reforming of unfinished petroleum derivatives and whose total refinery capacity (including the refinery capacity of any person or entity who controls, is controlled by or is under common control with, such refiner) is greater than 65,000 barrels per day.

"Stage II vapor recovery system" means any equipment designed and used to collect, recover, or destroy gasoline vapors displaced during the transfer of gasoline into a motor vehicle fuel tank.

"Submerged fill pipe" means any fill pipe the discharge opening of which is entirely submerged when the liquid level is six inches above the bottom of the tank; or, when applied to a tank which is loaded from the side, any fill pipe the discharge opening of which is entirely submerged when at the minimum operating level.

"Vapor-mounted" means a primary seal mounted so there is an annular vapor space underneath the seal. The annular vapor space is bounded by the bottom of the primary seal, the tank shell, the liquid surface, and the floating roof.

"Vapor tight" means capable of holding a pressure of 18 inH20 and a vacuum of 6 inH20 without sustaining a pressure change of more than 3 inH20 in 5 minutes.

"Waxy, heavy pour crude oil" means a crude oil with a pour point of 50°F or higher as determined by the American Society for Testing and Materials Standard D97-66, "Test for Pour Point of Petroleum Oils" (see Appendix M).

§ 120-04-3703. Standard for volatile organic compounds.

A. Petroleum liquid storage - fixed roof tanks.

1. No owner or other person shall use or permit the use of any fixed roof tank of more than 40,000 gallons capacity for storage of petroleum liquids, unless such tank is equipped with a control method which will remove, destroy or prevent the discharge into the atmosphere of at least 90% by weight of volatile organic compound emissions.

2. Achievement of the emission standard in subdivision A 1 of this section by use of methods in § 120-04-3704 A will be acceptable to the board.

3. The provisions of subsection A of this section shall not be applicable to fixed roof tanks having capacities less than 400,000 gallons for crude oil or condensate stored, processed or treated at a drilling and production facility prior to custody transfer.

4. The owner of a fixed roof tank subject to the provisions of subdivision A 1 of this section shall:

a. When the fixed roof tank is equipped with an internal floating roof, perform a visual inspection annually of the floating cover through roof hatches, to ascertain compliance with the specifications in subdivisions A 4 a (1) and (2).

(1) The cover should be uniformly floating on or above the liquid and there should be no visible defects in the surface of the cover or liquid accumulated on the cover.

(2) The seal must be intact and uniformly in place around the circumference of the cover between the cover and tank wall.

b. Perform a complete inspection of the cover and seal and record the condition of the cover and seal when the tank is emptied for nonoperational reasons such as maintenance, an emergency, or other similar purposes.

c. Maintain records of the throughput quantities and types of petroleum liquids stored, the average monthly storage temperature and true vapor pressure of the liquid as stored, and the results of the inspections performed under the provisions of subdivisions A 4 a and b of this section.

B. Petroleum liquid storage - floating roof tanks.

1. No owner or other person shall use or permit the use of any floating roof tank of more than 40,000 gallons capacity for storage of petroleum liquids, unless such tank is equipped with a control method which will remove, destroy or prevent the discharge into the atmosphere of at least 90% by weight of volatile organic compound emissions.

2. Achievement of the emission standard in subdivision B 1 of this section by use of methods in § 120-04-3704 B will be acceptable to the board.

3. The provisions of subsection B of this section shall not be applicable to the following:

a. Floating roof tanks having capacities less than 400,000 gallons for crude oil or condensate stored, processed or treated at a drilling and production facility prior to custody transfer.

b. Floating roof tanks storing waxy, heavy pour crude oil.

4. The owner of a floating roof tank subject to the provisions of subdivision B 1 of this section shall:

a. Perform routine inspections annually which shall include a visual inspection of the secondary seal gap.

b. When the floating roof is equipped with a vapor-mounted primary seal, measure the secondary seal gap annually in accordance with subdivisions B 4 b (1) and (2) of this section.

(1) Physically measuring the length and width of all gaps around the entire circumference of the secondary seal in each place where a 1/8-inch. uniform diameter probe passes freely (without forcing or binding against the seal) between the seal and tank wall; and

(2) Summing the area of the individual gaps.

c. Maintain records of the types of petroleum liquids stored, the maximum true vapor pressure of the liquid as stored, and the results of the inspections performed under the provisions of subdivisions B 4 a and b of this section.

C. Gasoline bulk loading - bulk terminals.

1. No owner or other person shall cause or permit the discharge into the atmosphere from a bulk gasoline terminal (including any appurtenant equipment necessary to load the tank truck compartments) any volatile organic compound in excess of .67 pounds per 1,000 gallons of gasoline loaded.

2. Achievement of the emission standard in subdivision C 1 of this section by use of methods in § 120-04-3704 C will be acceptable to the board.

D. Gasoline bulk loading - bulk plants.

1. No owner or other person shall use or permit the use of any bulk gasoline plant (including any appurtenant equipment necessary to load or unload tank trucks and account trucks) unless such plant is equipped with a vapor control system that will remove, destroy or prevent the discharge into the atmosphere of at least 77% by weight of volatile organic compound emissions.

2. Achievement of the emission standard in subdivision D 1 of this section by use of methods in § 120-04-3704 D will be acceptable to the board.

3. The provisions of subsection D of this section shall not be applicable to facilities whose ~~total~~ average ~~gasoline~~ *daily* throughput *of gasoline* is less than 4,000 gallons per working day *when based on a 30-day rolling average. Average daily throughput means the average daily amount of gasoline pumped at a gasoline dispensing facility during the most recent 30-day period. Average daily throughput shall be calculated for the two most recent consecutive calendar years. If during this two-year period or any period thereafter, the average daily throughput exceeds 4,000 gallons per working day, the facility is no longer exempt from the provisions of subdivision D 1 of this section.*

E. Transfer of gasoline - gasoline dispensing facilities - stage I *vapor control systems* .

1. No owner or other person shall transfer or permit the transfer of gasoline from any tank truck into any stationary storage tank unless such tank is equipped with a vapor control system that will remove, destroy or prevent the discharge into the atmosphere of at least 90% by weight of volatile organic compound emissions.

2. Achievement of the emission standard in subdivision E 1 of this section by use of methods in § 120-04-3704 E will be acceptable to the board.

3. The provisions of subsection E of this section shall not apply to the following:

a. Transfers made to storage tanks that are either less than 250 gallons in capacity or located at facilities whose ~~total~~ average ~~gasoline~~ *monthly* throughput *of gasoline* is less than 10,000 gallons ~~per month~~ .

b. Transfers made to storage tanks equipped with floating roofs or their equivalent.

F. Transfer of gasoline - gasoline dispensing facilities - Stage II vapor recovery systems.

1. No owner or other person shall transfer or permit the transfer of gasoline into the fuel tank of any motor vehicle at any affected gasoline dispensing facility unless the transfer is made using a certified Stage II vapor recovery system that is designed, operated, and maintained such that the vapor recovery system removes, destroys or prevents the discharge into the atmosphere of at least 95% by weight of volatile organic compound emissions.

2. Achievement of the emission standard in subdivision F 1 of this section by use of methods in § 120-04-3704 F will be acceptable to the board.

3. The provisions of subsection F of this section shall apply to affected facilities in the Northern Virginia and Richmond Volatile Organic Compound Emissions Control Areas designated in Appendix P. The affected gasoline facilities shall be in compliance with the emissions standard in subdivision F 1 of this section according to the following schedule:

a. Facilities which begin actual construction on or after January 1, 1993, must comply upon start-up unless the facility can prove it is exempt under the provisions of subdivision F 4 of this section.

b. Facilities which begin actual construction after November 15, 1990, and before January 1, 1993, must comply by May 15, 1993.

c. Facilities which begin actual construction on or before November 15, 1990, and dispense an average monthly throughput of 100,000 gallons or more of gasoline must comply by November 15, 1993.

d. All other affected facilities which begin actual construction on or before November 15, 1990, must comply by November 15, 1994.

4. The provisions of subsection F of this section shall not apply to the following facilities:

a. Gasoline dispensing facilities with an average monthly throughput of 10,000 gallons or less.

b. Gasoline dispensing facilities owned by independent small business gasoline marketers with an average monthly throughput of less than 50,000 gallons.

c. Gasoline dispensing devices that are used exclusively for refueling marine vehicles, aircraft, farm equipment, and emergency vehicles.

5. Any gasoline dispensing facility subject to the provisions of subsection F of this section shall also comply with the provisions of subsection E of this section (Stage I vapor controls).

6. In accordance with the provisions of AQP-9, Procedures for Implementation of Regulations Covering Stage II Vapor Recovery Systems for Gasoline Dispensing Facilities (see Appendix S), owners of affected gasoline dispensing facilities shall:

a. Perform tests, before the equipment is made available for use by the public, on the entire Stage II vapor recovery system to ensure the proper functioning of nozzle automatic shut-off mechanisms and flow prohibiting mechanisms where applicable, and perform a pressure decay/leak test, a vapor space tie test, and a liquid blockage test.

b. No later than 15 days after system testing is completed, submit to the board documentation showing that the entire Stage II vapor recovery system has passed the tests outlined in subdivision F 6 a of this section.

c. Ensure that the Stage II vapor recovery system is vapor tight by performing a pressure decay/leak test and a liquid blockage test at least every five years, upon major system replacement or modification, or if requested by the board after evidence of a system malfunction which compromises the efficiency of the system.

d. Notify the board at least two days prior to Stage II vapor recovery system testing as required by subdivisions F 6 a and F 6 c of this section.

e. Conspicuously post operating instructions for the vapor recovery system in the gasoline dispensing area which includes the following:

(1) A clear description of how to correctly dispense gasoline with the vapor recovery nozzles.

(2) A warning that repeated attempts to continue dispensing gasoline, after the system has indicated that the vehicle fuel tank is full (by automatically shutting off) may result in spillage or recirculation of gasoline.

(3) A telephone number to report problems experienced with the vapor recovery system to the board.

f. Conspicuously post "Out Of Order" signs on any nozzle associated with any aboveground part of the vapor recovery system which is defective until the system has been repaired.

g. Provide adequate training and written instructions to assure proper operation of the vapor recovery system.

h. Perform routine maintenance inspections of the Stage II vapor recovery system on a daily and monthly basis and record the inspection results.

i. Maintain records on site, in a form and manner acceptable to the board, of the type and duration of any failures of the system, maintenance, repair and testing of the system, inspections, and enforcement actions. Records shall be retained for a period of at least two years, unless specified otherwise, and shall be made immediately available for inspection by the board upon request.

~~F~~ *G* . Tank trucks/account trucks and vapor collection systems.

1. No owner or other person shall use or permit the use of any tank truck or account truck that is loaded or unloaded at facilities subject to the provisions of subsection C, D or E of this section unless such truck is designed, maintained and certified to be vapor tight. In addition, there shall be no avoidable visible liquid leaks. Invariably there will be a few drops of liquid from disconnection of dry breaks in liquid lines even when well maintained; these drops are allowed.

2. Vapor-laden tank trucks or account trucks exclusively serving facilities subject to subsection D or E of this section may be refilled only at facilities in compliance with subsection C of this section.

3. Tank truck and account truck hatches shall be closed at all times during loading and unloading operations (periods during which there is liquid flow into or out of the truck) at facilities subject to the provisions of subsection C, D or E of this section.

4. During loading or unloading operations at facilities subject to the provisions of subsection C, D or E of this section, there shall be no volatile organic compound concentrations greater than or equal to 100% of the lower explosive limit (LEL, measured as propane) at 2.5 centimeters around the perimeter of a potential leak source as detected by a combustible gas detector. In addition, there shall be no avoidable visible liquid leaks. Invariably there will be a few liquid drops from the disconnection of well-maintained bottom loading dry breaks and the raising of well-maintained top loading vapor heads; these few drops are allowed. The vapor collection system includes all piping, seals, hoses, connection, pressure-vacuum vents and other possible leak sources between the truck and the vapor disposal unit and between the storage tanks and vapor recovery unit.

5. The vapor collection and vapor disposal equipment must be designed and operated to prevent gauge pressure in the tank truck from exceeding 18 inH2O and prevent vacuum from exceeding 6 inH2O.

6. Testing to determine compliance with subdivision ~~F~~ ~~1~~ *G 1* of this section shall be conducted and reported and data shall be reduced as set forth in procedures approved by the board using test methods specified therein. All tests shall be conducted by, or under the direction of, a person qualified by training or experience in the field of air pollution testing, or tank truck maintenance and testing and approved by the board.

7. Monitoring to confirm the continuing existence of leak tight conditions specified in subdivision ~~F~~ ~~4~~ *G 4* of this section shall be conducted as set forth in procedures approved by the board using test methods specified therein.

8. Owners of tank trucks and account trucks subject to the provisions of subdivision ~~F~~ ~~1~~ *G 1* of this section shall certify, each year that the trucks are vapor tight in accordance with test procedures specified in subdivision ~~F~~ ~~6~~ *G 6* of this section. Trucks that are not vapor tight must be repaired within 15 days of the test and be tested and certified as vapor tight.

9. Each truck subject to the provisions of subdivision ~~F~~ ~~1~~ *G 1* of this section shall have information displayed on the tank indicating the expiration date of the certification and such other information as may be needed by the board to determine the validity of the certification. The means of display and location of the above information shall be in a manner acceptable to the board.

10. An owner of a vapor collection/control system shall repair and retest the system within 15 days of the testing, if it exceeds the limit specified in subdivision ~~F~~ ~~4~~ *G 4* of this section.

11. The owner of a tank/account truck or vapor collection/control system or both subject to the provisions of this section shall maintain records of all certification testing repairs. The records must identify the tank/account truck, vapor collection system, or vapor control system; the date of the test or repair; and, if applicable, the type of repair and the date of retest. The records must be maintained in a legible, readily available condition for at least two years after the date testing or repair was completed.

12. The records of certification tests required by subdivision ~~F~~ ~~11~~ *G 11* of this section shall, as a minimum, contain the following:

a. The tank/account truck tank identification number.

b. The initial test pressure and the time of the reading.

c. The final test pressure and the time of the reading.

d. The initial test vacuum and the time of the reading.

e. The final test vacuum and the time of the

reading.

f. Name and the title of the person conducting the test.

13. Copies of all records and reports required by this section shall immediately be made available to the board, upon verbal or written request, at any reasonable time.

14. The board may, at any time, monitor a tank/account truck, vapor collection system, or vapor control system, by the method referenced in subdivision ~~F 6~~ *G 6* or ~~F 7~~ *G 7* of this section to confirm continuing compliance with subdivision ~~F 1~~ *G 1* or ~~F 4~~ *G 4* of this section.

15. If, after over one year of monitoring (i.e., at least two complete annual checks), the owner of a truck subject to the provisions of subdivision ~~F 6~~ *G 6* of this section feels that modification of the requirements are in order, he may request in writing to the board that a revision be made. The request should include data that have been developed to justify any modifications in the monitoring schedule. On the other hand, if the board finds an excessive number of leaks during an inspection, or if the owner finds an excessive number of leaks during scheduled monitoring, consideration shall be given to increasing the frequency of inspection.

§ 120-04-3704. Control technology guidelines.

A. Petroleum liquid storage - fixed roof tanks.

1. The tank should be a pressure tank maintaining working pressure sufficient at all times to prevent vapor loss to the atmosphere, or be designed and equipped with one of the following vapor control systems:

a. An internal floating roof resting on the surface of the liquid contents and equipped with a closure seal, or seals, to close the space between the roof edge and tank shell. All tank gauging and sampling devices should be vapor tight except when gauging or sampling is taking place.

b. Any system of equal or greater control efficiency to the system in subdivision A 1 a of this section, provided such system is approved by the board.

2. There should be no visible holes, tears or other openings in the seal or any seal fabric.

3. All openings, except stub drains, should be equipped with a cover, seal or lid. The cover, seal or lid should be in a closed position at all times except when the device is in actual use. Automatic bleeder vents should be closed at all times except when the roof is floated off or landed on the roof leg supports. Rim vents, if provided, should be set to open when the roof is being floated off the roof leg supports or at the manufacturer's recommended setting.

4. The exterior above ground surfaces (exposed to sunlight) should be painted white, light pastels, or light metallic and such exterior paint should be periodically maintained in good condition. Repainting may be performed during normal maintenance periods.

B. Petroleum liquid storage - floating roof tanks.

1. The tank should be designed and equipped with one of the following vapor control systems:

a. An external floating roof resting on the surface of the liquid contents and equipped with a seal closure device (meeting the specifications set forth in subdivisions B 2 and 3 of this section) to close the space between the roof edge and tank shell. All tank gauging and sampling devices should be vapor tight except when gauging or sampling is taking place.

b. Any system of equal or greater control efficiency to the system in subdivision B 1 a of this section, provided such system is approved by the board.

2. Unless the tank is a welded tank fitted with a metallic-type shoe seal which has a secondary seal from the top to the shoe seal to the tank wall (shoe-mounted secondary), the tank should be fitte with a continuous secondary seal extending from the floating roof to the tank wall (a rim-mounted secondary) if:

a. The tank is a welded tank, the true vapor pressure of the contained liquid is 4.0 psi or greater, and the primary seal is one of the following:

(1) A metallic-type shoe seal.

(2) A liquid-mounted foam seal.

(3) A liquid-mounted liquid-filled type seal.

(4) Any other seal closure device which can be demonstrated equivalent to the primary seals specified in subdivisions B 2 a (1) through (3) of this section.

b. The tank is a riveted tank, the true vapor pressure of the contained liquid is 1.5 psi, or greater, and the seal closure device is as described in subdivision B 2 a of this section.

c. The tank is a welded or riveted tank, the true vapor pressure of the contained liquid is 1.5 psi, or greater, and the primary seal is vapor mounted. When such primary seal closure device can b

demonstrated equivalent to the primary seals described in subdivision B 2 a of this section, the provisions of that subdivision apply.

3. The seal closure devices should meet the following requirements:

a. There should be no visible holes, tears or other openings in the seal or any seal fabric.

b. The seal should be intact and uniformly in place around the circumference of the floating roof between the floating roof and the tank wall.

c. The areas where the gap between the secondary seal, installed pursuant to subdivision B 2 c of this section, and the tank wall exceeds 1/8 inch in width shall be calculated in square inches. The sum of all such areas shall not exceed 1.0 square inch per foot of tank diameter.

4. All openings, except for automatic bleeder vents, rim space vents and leg sleeves, should provide a projection below the liquid surface. All openings, except stub drains, should be equipped with a cover, seal or lid. The cover, seal or lid should be in a closed position at all times except when the device is in actual use. Automatic bleeder vents should be closed at all times except when the roof is floated off or landed on the roof leg supports. Rim vents, if provided, should be set to open when the roof is being floated off the roof leg supports or at the manufacturer's recommended setting. Any emergency roof drain should be provided with a slotted membrane fabric cover or equivalent cover that covers at least 90% of the area of the opening.

5. The exterior above ground surfaces (exposed to sunlight) should be painted white, light pastels, or light metallic and such exterior paint should be periodically maintained in good condition. Repainting may be performed during normal maintenance periods.

C. Gasoline bulk loading - bulk terminals.

The control system should consist of the following:

1. A vapor collection and disposal system with the vapor disposal portion consisting of one of the following:

a. Compression - refrigeration - adsorption system.

b. Refrigeration system.

c. Oxidation system.

d. Any system of equal or greater control efficiency to the systems in subdivisions C 1 a through c of this section, provided such system is approved by the board.

2. A vapor collection and disposal system with the vapor collection portion meeting the following criteria:

a. Loading should be accomplished in such manner that all displaced vapor and air will be vented only to the vapor disposal system. Measures should be taken to prevent liquid drainage from the loading device when it is not in use or to accomplish substantially complete drainage before the loading device is disconnected.

b. The pressure relief valves on storage containers and tank trucks should be set to release at no less than 0.7 psi or the highest possible pressure (in accordance with the following National Fire Prevention Association Standards: NFPA 385, Standard for Tank Vehicles for Flammable and Combustible Liquids; NFPA 30, Flammable and Combustible Liquids Code; NFPA 30A, Automotive and Marine Service Station Code (see Appendix M)).

c. Pressure in the vapor collection lines should not exceed tank truck pressure relief valve settings.

d. All loading and vapor lines should be equipped with fittings which make vapor tight connections and which close when disconnected.

D. Gasoline bulk loading - bulk plants.

1. The control system should consist of one of the following:

a. Submerged filling of account trucks and storage tanks (either top-submerged or bottom-fill) plus a vapor balance (displacement) system to control volatile organic compounds displaced by gasoline delivery to the storage tank and account truck.

b. Top loading vapor recovery method of filling account trucks and storage tanks plus a vapor balance (displacement) system to control volatile organic compounds displaced by gasoline delivery to the storage tank and account truck.

c. Any system of equal or greater control efficiency to the system in subdivision D 1 a or b of this section, provided such system is approved by the board.

2. The control system in subdivisions D 1 a and b of this section should meet the following equipment specifications and operating procedures:

a. For top-submerged and bottom-fill. The fill pipe should extend to within six inches of the bottom of the storage tank and account truck during top-submerged filling operations. Any bottom fill is acceptable if the inlet is flush with the tank bottom.

b. For the balance system:

(1) There should be no leaks in the account trucks' and tank trucks' pressure vacuum relief valves and hatch covers, nor tank trucks, account trucks, storage tanks or associated vapor return lines during loading or unloading operations.

(2) The pressure relief valves on storage tanks, account trucks and tank trucks should be set to release at no less than 0.7 psi or the highest possible pressure (in accordance with the following National Fire Prevention Association Standards: NFPA 385, Standard for Tank Vehicles for Flammable and Combustible Liquids; NFPA 30, Flammable and Combustible Liquids Code; NFPA 30A, Automotive and Marine Service Station Code (see Appendix M)).

(3) Pressure in the vapor collection lines should not exceed account truck or tank truck pressure relief valve settings.

(4) All loading and vapor lines should be equipped with fittings which make vapor tight connections and which close when disconnected.

E. Transfer of gasoline - gasoline dispensing facilities - stage I *vapor control systems* .

The control system should consist of the following:

1. A submerged fill pipe.

2. A vapor control system with the vapor recovery portion consisting of one of the following:

a. A vapor tight return line from the storage container to the tank truck which shall be connected before gasoline is transferred into the container.

b. Any adsorption system or condensation system.

c. Any system of equal or greater control efficiency to the systems in subdivision E 2 a or b of this section, provided such system is approved by the board.

3. A vapor control system with the vapor balance portion meeting the following criteria:

a. There should be no leaks in the tank trucks' pressure vacuum relief valves and hatch covers, nor truck tanks, storage tanks and associated vapor return lines during loading or unloading operations.

b. The pressure relief valves on storage containers and tank trucks should be set to release at no less than 0.7 psi or the highest possible pressure (in accordance with the following National Fire Prevention Association Standards: NFPA 385, Standard for Tank Vehicles for Flammable and Combustible Liquids; NFPA 30, Flammable and Combustible Liquids Code; NFPA 30A, Automotive and Marine Service Station Code (see Appendix M)).

c. Pressure in the vapor collection lines should not exceed tank truck pressure relief valve settings.

d. All loading and vapor lines should be equipped with fittings which make vapor tight connections and which close when disconnected.

F. Transfer of gasoline - gasoline dispensing facilities - Stage II vapor recovery systems.

1. Stage II vapor recovery systems shall be limited to those certified systems approved under the provisions of AQP-9, Procedures for Implementation of Regulations Covering Stage II Vapor Recovery Systems for Gasoline Dispensing Facilities (see Appendix S), which utilize coaxial hoses and vapor check valves in the nozzle (i.e., no remote check valves).

2. Stage II vapor recovery systems installed prior to January 1, 1993, must meet the specifications of a system certified by the California Air Resources Board. Owners of Stage II vapor recovery systems utilizing remote check valves and dual vapor recovery hoses shall replace these components with check valves in the nozzle and with coaxial hoses by January 1, 1995.

§ 120-04-3705. Standard for visible emissions.

The provisions of Rule 4-1 (Emission Standards for Visible Emissions and Fugitive Dust/Emissions) apply.

§ 120-04-3706. Standard for fugitive dust/emissions.

The provisions of Rule 4-1 (Emission Standards for Visible Emissions and Fugitive Dust/Emissions) apply.

§ 120-04-3707. Standard for odor.

The provisions of Rule 4-2 (Emission Standards for Odor) apply.

§ 120-04-3708. Standard for noncriteria pollutants.

The provisions of Rule 4-3 (Emission Standards for Noncriteria Pollutants) apply.

§ 120-04-3709. Compliance.

The provisions of § 120-04-02 (Compliance) apply.

§ 120-04-3710. Test methods and procedures.

The provisions of § 120-04-03 (Emission testing) apply.

§ 120-04-3711. Monitoring.

The provisions of § 120-04-04 (Monitoring) apply.

§ 120-04-3712. Notification, records and reporting.

The provisions of § 120-04-05 (Notification, records and reporting) apply.

§ 120-04-3713. Registration.

The provisions of § 120-02-31 (Registration) apply.

§ 120-04-3714. Facility and control equipment maintenance or malfunction.

The provisions of § 120-02-34 (Facility and control equipment maintenance or malfunction) apply.

§ 120-04-3715. Permits.

A permit may be required prior to beginning any of the activities specified below and the provisions of Part V (New and Modified Sources) and Part VIII (Permits for New and Modified Sources) may apply. Owners contemplating such action should contact the appropriate regional office for guidance.

A. Construction of a facility.

B. Reconstruction (replacement of more than half) of a facility.

C. Modification (any physical change to equipment) of a facility.

D. Relocation of a facility.

E. Reactivation (restart-up) of a facility.

APPENDIX P.
VOLATILE ORGANIC COMPOUND EMISSIONS CONTROL AREAS.

~~Volatile Organic Compound Emissions Control Areas are geographically defined as follows:~~

~~Air Quality Control Region 1~~	~~None~~
~~Air Quality Control Region 2~~	~~None~~
~~Air Quality Control Region 3~~	~~None~~
~~Air Quality Control Region 4~~	~~Stafford County~~
~~Air Quality Control Region 5~~	~~Richmond City~~ ~~Chesterfield County~~ ~~Henrico County~~
~~Air Quality Control Region 6~~	~~Chesapeake City~~ ~~Hampton City~~ ~~Newport News City~~ ~~Norfolk City~~ ~~Portsmouth City~~ ~~Suffolk City~~ ~~Virginia Beach City~~
~~Air Quality Control Region 7~~	~~Alexandria City~~ ~~Fairfax City~~ ~~Falls Church City~~ ~~Manassas City~~ ~~Manassas Park City~~ ~~Arlington County~~ ~~Fairfax County~~ ~~Loudoun County~~ ~~Prince William County~~

Emissions Control Areas are geographically defined below by locality for the pollutants indicated.

A. Volatile Organic Compounds

1. Northern Virginia Emissions Control Area

Arlington County	*Alexandria City*
Fairfax County	*Fairfax City*
Loudoun County	*Falls Church City*
Prince William County	*Manassas City*
Stafford County	*Manassas Park City*

2. Richmond Emissions Control Area

Charles City County	*Colonial Heights City*
Chesterfield County	*Hopewell City*
Hanover County	*Richmond City*
Henrico County	

B. Nitrogen Oxides

1. Northern Virginia Emissions Control Area

Arlington County	*Alexandria City*
Fairfax County	*Fairfax City*
Loudoun County	*Falls Church City*
Prince Willism County	*Manassas City*
Stafford County	*Manassas Park City*

2. Richmond Emissions Control Area

Charles City County	*Colonial Heights City*
Chesterfield County	*Hopewell City*
Hanover County	*Richmond City*
Henrico County	

3. Hampton Roads Emissions Control Area

Chesapeake City	*Portsmouth City*
Hampton City	*Suffolk City*
Newport News City	*Virginia Beach City*
Norfolk City	

APPENDIX S.
AIR QUALITY PROGRAM POLICIES AND PROCEDURES.

I. General.

A. In order for the Commonwealth to fulfill its obligations under the federal Clean Air Act, some provisions of these regulations are required to be approved by the U.S. Environmental Protection Agency as part of the State Implementation Plan and when approved those provisions become federally enforceable.

B. In cases where these regulations specify that procedures or methods shall be approved by, acceptable to or determined by the board or other similar phrasing or specifically provide for decisions to be made by the board

or department, it may also be necessary to have such actions (approvals, determinations, exemptions, exclusions, or decisions) approved by the U.S. Environmental Protection Agency as part of the State Implementation Plan in order to make them federally enforceable. In accordance with U.S. Environmental Protection Agency regulations and policy, it has been determined that it is necessary for the procedures listed in Section II of this appendix to be approved as part of the State Implementation Plan.

C. Failure to include in this appendix any procedure mentioned in the regulations shall not invalidate the applicability of the procedure.

D. Copies of materials listed in this appendix may be examined by the public at the headquarters office of the Department of Air Pollution Control, Eighth Floor, Ninth Street Office Building, 200-202 North Ninth Street, Richmond, Virginia between 8:30 a.m. and 4:30 p.m. of each business day.

II. Specific documents.

A. Procedures for Testing Facilities Subject to Emission Standards for Volatile Organic Compounds, AQP-1, July 1, 1991.

B. Procedures for Determining Compliance with Volatile Organic Compound Emission Standards Covering Surface Coating Operations, AQP-2, July 1, 1991.

C. Procedures for the Measurement of Capture Efficiency for Determining Compliance with Volatile Organic Compound Emission Standards Covering Surface Coating Operations, AQP-3, July 1, 1991.

D. Procedures for Maintaining Records for Surface Coating Operations and Graphic Arts Printing Processes, AQP-4, July 1, 1991.

E. (Reserved)

F. Procedures for Implementation of Regulations Covering Stage II Vapor Recovery Systems For Gasoline Dispensing Facilities, AQP-9, January 1, 1993.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF AIR POLLUTION CONTROL

STAGE II VAPOR RECOVERY SYSTEM REGISTRATION AND EQUIPMENT APPROVAL FORM

REGISTRAR OF REGULATIONS

PLEASE TYPE OR PRINT CLEARLY.

92 MAY 13 AM 10:33

☐ 1. FACILITY OWNER:

Name:_____ Phone:(_____)_____

Business Mailing Address:_____

City, State:_____ ZIP:_____

☐ 2. FACILITY OPERATOR/LESSEE:

Name:_____ Phone:(_____)_____

Business Mailing Address:_____

City, State:_____ ZIP:_____

☐ 3. FACILITY INFORMATION:

Name:_____ Phone:(_____)_____

Street Address:_____

City, State:_____ ZIP:_____

☐ 4. TYPE OF VAPOR COLLECTION AND CONTROL SYSTEM (check one only):
☐ Vapor Balance ☐ Vacuum Assist ☐ Other:_____

☐ 5. VAPOR COLLECTION AND CONTROL EQUIPMENT INFORMATION: Only equipment which has already been approved and certified by the California Air Resources Board (CARB) is acceptable.

Equipment	No. of	Manufacturer's Name	Model No.	CARB Number (i.e., Executive Order #)
NOZZLES				
HOSES				
DISPENSERS				

☐ 6. ANTICIPATED DATES OF INSTALLATION:

Underground Piping:_____/_____/_____ (mm dd yy) Aboveground Equipment:_____/_____/_____ (mm dd yy)

☐ 7. STATEMENT OF NOTIFICATION (Sign and return the white copy):
I certify that I have provided the above information, and to the best of my knowledge it is true and complete.

_____ _____
Signature of legally responsible person Date

Name:_____ Title:_____

Business Address:_____ Phone:(_____)_____

City, State:_____ ZIP:_____

☐ 8. STATEMENT OF COMPLIANCE (Sign and return the yellow copy when installation of equipment has been completed): I certify that the equipment listed in item #5 above has been installed and is operating in compliance with Rule 4-37 of VR 120-01.

_____ _____
Signature of legally responsible person (#7 above) Date

* * * * * * * *

Title of Regulation: **VR 120-01. Regulations for the Control and Abatement of Air Pollution - New and Modified Stationary Sources.**

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

Public Hearing Date: July 8, 1992 - 10 a.m.
(See Calendar of Events section for additional information)

Summary

The major provisions of the proposal are summarized below:

1. The 1990 Clean Air Act Amendments mandate certain changes to Virginia's nonattainment permit requirements covered in § 120-08-03. The major changes related to the requirements of the Clean Air Act appear in the definitions and in subsections F, M and N. The definitions of "major stationary source," "net emissions increase," "nonattainment pollutant" and significant" have been amended to meet various requirements of Title I of the Clean Air Act. Subsection F, regarding standards, and subsection M, regarding offsets, have been amended to meet the requirements of §§ 173(a) and 182 of the Clean Air Act. Subsection N, regarding de minimis increases and modification alternatives, has been added to meet the requirements of § 182(c)(6) through (8). Where appropriate, nitrogen oxides has been added to the language in this section regarding the relevant nonattainment pollutants.

2. Through these proposed amendments, the board is expanding the opportunity for public participation with regard to permitting. Current public participation requirements have been combined with new requirements in a separate public participation section in §§ 120-08-01, 120-08-02 and 120-08-03. In §§ 120-08-02 and 120-08-03, the proposal requires the applicant to provide public notice and an informational briefing in addition to the public hearing and public comment period now provided by the board. In § 120-08-01, the proposal requires the applicant to provide public notice only, in addition to the current public participation provisions.

3. The definition of "building, structure, or facility" in § 120-08-03 has expanded to include installation. The definition of "installation" has been deleted. This change removes the dual definition from this section making the definition of "building, structure, facility or installation" identical to that in § 120-08-02.

4. The proposal amends the provision concerning who signs applications for permits in §§ 120-08-01, 120-08-02 and 120-08-03 to conform to similar provisions in the regulations of other state environmental agencies.

5. The proposal adds a provision to §§ 120-08-01, 120-08-02 and 120-08-03 concerning the statutory requirement for all applicants to provide notification from the locality that the location and operation of the facility are consistnt with certain local ordinances.

6. The proposal adds subsections on reactivation and shutdown, transfer of permits, and revocation and enforcement of permits to §§ 120-08-01, 120-08-02 and 120-08-03.

7. The proposal amends Appendix R to provide an increase in some general exemption levels and in some specific exemption levels. The proposal also amends section IX, regarding exemption levels for sources emitting toxic pollutants, by allowing sources applying for modification permits to be exempt from the permit requirements on the basis of the increased emissions alone.

VR 120-01. Regulations for the Control and Abatement of Air Pollution - New and Modified Stationary Source Permits.

PART VIII.
PERMITS FOR NEW AND MODIFIED SOURCES.

§ 120-08-01. Permits - new and modified stationary sources.

A. Applicability.

1. Except as provided in subsection A 3 of this section, the provisions of this section apply to the construction, reconstruction, relocation or modification of any stationary source.

2. The provisions of this ~~rule~~ *section* apply throughout the Commonwealth of Virginia.

3. The provisions of this section do not apply ~~to the reactivation of any emissions unit and~~ to any facility exempted by Appendix R. *Exemption from the requirement to obtain a permit under this section shall not relieve any owner of the responsibility to comply with any other applicable provisions of these regulations or any other applicable regulations, laws, ordinances and orders of the governmental entities having jurisdiction. Any facility which is exempt from the provisions of this section based on the criteria in Appendix R but which exceeds the applicability thresholds for any emmission standard in Part IV if it were an existing source or any standard of performance in Part V shall be subject to the more restrictive of the provisions of either the emission standard in Part IV or the standard of performance in Part V.*

4. Where a source is constructed or modified in increments which individually are not subject to

approval under this section and which are not part of a program of construction or modification in planned incremental phases approved by the board, all such increments shall be added together for determining the applicability of this section.

4. *5.* Unless specified otherwise, the provisions of this section are applicable to various sources as follows:

a. Provisions referring to "sources," "new and/or modified sources" or "stationary sources" are applicable to the construction, reconstructi or modification of all stationary sources (including major stationary sources and major modifications) and the emissions therefrom to the extent that such sources and their emissions are not subject to the provisions of § 120-08-02 or § 120-08-03.

b. Provisions referring to "major stationary sources" are applicable to the construction, reconstruction or modification of all major stationary sources.

c. In cases where the provisions of § 120-08-02 or § 120-08-03 conflict with those of this section, the provisions of § 120-08-02 or § 120-08-03 shall prevail.

B. Definitions.

1. For the purpose of these regulations and subsequent amendments or any orders issued by the board, the words or terms shall have the meaning given them in subsection B 3 of this section.

2. As used in this section, all terms not defined herein shall have the meaning given them in Part I, unless otherwise required by context.

3. Terms defined.

"Allowable emissions" means the emission rate of a stationary source calculated by using the maximum rated capacity of the source (unless the source is subject to state or federally enforceable limits which restrict the operating rate and/or hours of operation) and the most stringent of the following:

(1) Applicable emission standards.

(2) The emission limitation specified as a state and federally enforceable permit condition, including those with a future compliance date.

(3) Any other applicable emission limitation, including those with a future compliance date.

"Begin actual construction" means initiation of permanent physical on-site construction of an emissions unit. This includes, but is not limited to, installation of building supports and foundations, laying of underground pipework, and construction of permanent storage structures. With respect to a change in method of operation, this term refers to those on-site activities other than preparatory activities which mark the initiation of the change. With respect to the initial location of a portable facility, this term refers to the delivery of any portion of the portable facility to the site.

"Commence," as applied to the construction, reconstruction or modification of an emissions unit, means that the owner has all necessary preconstruction approvals or permits and has either:

(1) Begun, or caused to begin, a continuous program of actual on-site construction, reconstruction or modification of the unit, to be completed within a reasonable time; or

(2) Entered into binding agreements or contractual obligations, which cannot be ~~cancelled~~ *canceled* or modified without substantial loss to the owner, to undertake a program of actual construction, reconstruction or modification of the unit, to be completed within a reasonable time.

"Construction" means fabrication, erection or installation of an emissions unit.

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

"Federally enforceable" means all limitations and conditions which are enforceable by the Administrator, including those requirements developed pursuant to 40 CFR Parts 60 and 61, requirements within the State Implementation Plan, and any permit requirements established pursuant to 40 CFR 52.21 or Part VIII , *including operating permits issued under an EPA-approved program that is incorporated into the State Implementation Plan and expressly requires adherence to any permit issued under such program.*

"Fixed capital cost" means the capital needed to provide all the depreciable components.

"Major modification" means any modification defined as such in § 120-08-02 or § 120-08-03, as may apply.

"Major stationary source" means any stationary source which emits, or has the potential to emit, 100 tons or more per year of any air pollutant.

"Modification" means any physical change in, change in the method of operation of, or addition to, an emissions unit which increases the ~~amount~~ *uncontrolled emission rate* of any air pollutant emitted into the atmosphere by the unit or which results in the emission of any air pollutant into the atmosphere not previously emitted, except that the following shall not, by themselves (unless previously limited by permit conditions), be considered modifications under this definition:

(1) Maintenance, repair and replacement which the board determines to be routine for a source type *and which does not fall within the definition of reconstuction* .

(2) An increase in the production rate of a unit, if that increase does not exceed the operating design capacity of that unit.

(3) An increase in the hours of operation.

(4) Use of an alternative fuel or raw material if, prior to the date any provision of these regulations becomes applicable to the source type, the emissions unit was designed to accommodate that alternative use. A unit shall be considered to be designed to accommodate an alternative fuel or raw material if provisions for that use were included in the final construction specifications.

~~(5) Use of an alternative fuel or raw material by reason of an order under Sections 2(a) and (b) of the Federal Energy Supply and Environmental Coordination Act of 1974 (or any superseding legislation), or by reason of a natural gas curtailment plan in effect pursuant to the Federal Power Act.~~

~~(6) Use of an alternative fuel by reason of an order or rule under Section 125 of the Federal Clean Air Act.~~

~~(7)~~ *(5)* The addition or use of any system or device whose primary function is the reduction of air pollutants, except when an emission control system is removed or is replaced by a system which the board considers to be less efficient.

~~(8) The change in ownership of an emissions unit.~~

"Modified source" means any stationary source (or portion thereof), the modification of which commenced on or after March 17, 1972.

"Necessary preconstruction approvals or permits" means those permits or approvals required under federal air quality control laws and regulations, and those air quality control law and regulations which are part of the State Implementation Plan.

"New source" means any stationary source (or portion thereof), the construction or relocation of which commenced on or after March 17, 1972; and any stationary source (or portion thereof), the reconstruction of which commenced on or after December 10, 1976.

"Potential to emit" means the maximum capacity of a stationary source to emit a pollutant under its physical and operational design. Any physical or operational limitation on the capacity of the source to emit a pollutant, including air pollution control equipment, and restrictions on hours of operation or on the type or amount of material combusted, stored, or processed, shall be treated as part of its design only if the limitation or its effect on emissions is state or federally enforceable. Secondary emissions do not count in determining the potential to emit of a stationary source.

"Public comment period" means a time during which the public shall have the opportunity to comment on the new or modified source permit application information (exclusive of confidential information), the preliminary review and analysis of the effect of the source upon the ambient air quality, and the preliminary decision of the board regarding the permit application.

"Reactivation" means beginning operation of an emissions unit that has been shut down.

"Reconstruction"

(1) Means the replacement of an emissions unit or its components to such an extent that:

(a) The fixed capital cost of the new components exceeds 50% of the fixed capital that would be required to construct a comparable entirely new unit, and

(b) It is technologically and economically feasible to meet the applicable emission standards prescribed under these regulations.

(2) Any determination by the board as to whether a proposed replacement constitutes reconstruction shall be based on:

(a) The fixed capital cost of the replacements in comparison to the fixed capital cost of the construction of a comparable entirely new unit;

(b) The estimated life of the unit after the replacements compared to the life of a comparable entirely new unit;

(c) The extent to which the components being replaced cause or contribute to the emissions from the unit; and

(d) Any economic or technical limitations on compliance with applicable standards of performance which are inherent in the proposed replacements.

"Secondary emissions" means emissions which occur or would occur as a result of the construction, reconstruction, modification or operation of a stationary source, but do not come from the stationary source itself. For the purpose of this section, secondary emissions must be specific, well defined, and quantifiable; and must impact upon the same general areas as the stationary source which causes the secondary emissions. Secondary emissions include emissions from any offsite support facility which

would not be constructed or increase its emissions except as a result of the construction or operation of the stationary source. Secondary emissions do not include any emissions which come directly from a mobile source, such as emissions from the tailpipe of a motor vehicle, from a train, or from a vessel.

"State enforceable" means all limitations and conditions which are enforceable by the board, including those requirements developed pursuant to § 120-02-11, requirements within any applicable order or variance, and any permit requirements established pursuant to Part VIII.

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

"Uncontrolled emission rate" means the emission rate from a source when operating at maximum capacity without air pollution control equipment. Air pollutant control equipment includes control equipment which is not vital to its operation, except that its use enable the source to conform to applicable air pollution control laws and regulations. Annual uncontrolled emissions shall be based on the maximum annual rated capacity (based on 8760 hours of operation per year) of the source, unless the source is subject to state and federally enforceable permit conditions which limit the annual hours of operation. Enforceable permit conditions on the type or amount of material combusted or processed may be used in determining the uncontrolled emission rate of a source. Secondary emissions do not count in determining the uncontrolled emission rate of a stationary source.

C. General.

1. No owner or other person shall begin actual construction, reconstruction or modification of any of the following types of sources without first obtaining from the board a permit to construct and operate or to modify and operate such source:

a. Any stationary source.

b. Any stationary source of hazardous air pollutants to which an emission standard prescribed under Part VI became applicable prior to the beginning of construction, reconstruction or modification. In the event that a new emission standard prescribed under Part VI becomes applicable after a permit is issued but prior to initial startup, a new permit must be obtained by the owner.

2. No owner or other person shall relocate any emissions unit subject to the provisions § 120-02-31 without first obtaining from the board a permit to relocate the unit.

3. No owner or other person shall reduce the outlet elevation of any stack or chimney which discharges any pollutant from an affected facility subject to the provisions of § 120-02-31 without first obtaining a permit from the board.

~~4. Prior to the decision of the board, permit applications as specified below shall be subject to a public comment period of at least 30 days. In addition, at the end of the public comment period, a public hearing will be held.~~

~~a. Applications for stationary sources of hazardous air pollutants as specified in subsection C 1 b of this section.~~

~~b. Applications for major stationary sources.~~

~~c. Applications for stationary sources which have the potential for public interest, as determined by the board. The identification of such sources shall be made using the following criteria:~~

~~(1) Whether the project is opposed by any person.~~

~~(2) Whether the project has resulted in adverse media comment.~~

~~(3) Whether the project has generated adverse comment through any public participation or governmental review process initiated by any other governmental agency.~~

~~(4) Whether the project has generated adverse comment by a local official, governing body or advisory board.~~

~~d. Applications for stationary sources for which any provision of the permit is to be based upon a good engineering practice (GEP) stack height that exceeds the height allowed by paragraphs 1 and 2 of the GEP definition. The demonstration specified in paragraph 3 of the GEP definition must be available during the public comment period.~~

4. The board may combine the requirements of and the permits for emission units within a stationary source subject to §§ 120-08-01, 120-08-02, and 120-08-03 into one permit. Likewise the board may require that applications for permits for emission units within a stationary source required by §§ 120-08-01, 120-08-02, and 120-08-03 be combined into one application.

D. Applications.

~~1. Application for a permit shall be made in the following manner. If the applicant is a partnership, a general partner shall sign the application. If the applicant is a corporation, association or cooperative, an officer shall sign the application. If the applicant is a sole proprietorship, the proprietor shall sign the application.~~

~~2.~~ *1.* A single application is required identifying each emissions unit. The application shall be submitted according to procedures approved by the board. However, where several units are included in one project, a single application covering all units in the project may be submitted. A separate application is required for each location.

~~3.~~ *2.* For projects with phased development, a single application should be submitted covering the entire project.

3. Any application form, report, or compliance certification submitted to the board shall be signed by a responsible official. A responsible official is defined as follows:

a. For a corporation, association or cooperative, a responsible official is either (i) the president, secretary, treasurer, or a vice-president of the corporation in charge of a principal business function, or any other person who performs similar policy or decision-making functions for the corporation, or (ii) a duly authorized representative of such corporation if the representative is responsible for the overall operation of one or more manufacturing, production, or operating facilities applying for or subject to a permit and either (a) the facilities employ more than 250 persons or have gross annual sales or expenditures exceeding $25 million (in second quarter 1980 dollars), or (b) the authority to sign documents has been assigned or delegated to such representative in accordance with corporate procedures.

b. For a partnership or sole proprietorship, a responsible official is a general partner or the proprietor, respectively.

c. For a municipality, state, federal, or other public agency, a responsible official is either a principal executive officer or ranking elected official. A principal executive officer of a federal agency includes the chief executive officer having responsibility for the overall operations of a principal geographic unit of the agency.

4. Any person signing a document under subsection D 3 above shall make the following certification:

"I certify under penalty of law that this document and all attachments were prepared under my direction or supervision in accordance with a system designed to assure that qualified personnel properly gather and evaluate the information submitted. Based on my inquiry of the person or persons who manage the system, or those persons directly responsible for gathering and evaluating the information, the information submitted is, to the best of my knowledge and belief, true, accurate, and complete. I am aware that there are significant penalties for submitting false information, including the possibility of fine and imprisonment for knowing violations."

5. As required under § 10.1-1321.1 of the Virginia Air Pollution Control Law, applications shall not be deemed complete unless the applicant has provided a notice from the locality in which the source is located or is to be located that the site and operation of the source are consistent with all local ordinances adopted pursuant to Chapter 11 (§ 15.1-427 et seq.) of Title 15.1 of the Code of Virginia.

E. Information required.

1. Each application for a permit shall include such information as may be required by the board to determine the effect of the proposed source on the ambient air quality and to determine compliance with the emission standards which are applicable. The information required shall include, but is not limited to, the following:

a. That specified on applicable permit forms furnished by the board. Any calculations shall include sufficient detail to permit assessment of the validity of such calculations. Completion of these forms serves as initial registration of new and modified sources.

b. Any additional information or documentation that the board deems necessary to review and analyze the air pollution aspects of the source, including the submission of measured air quality data at the proposed site prior to construction, reconstruction or modification. Such measurements shall be accomplished using procedures acceptable to the board.

2. The above information and analysis shall be determined and presented according to procedures and using methods acceptable to the board.

~~F. Standards for granting permits.~~

~~No permit will be granted pursuant to this section unless it is shown to the satisfaction of the board that the source will be designed, built and equipped to operate without causing a violation of the applicable provisions of these regulations and that the following standards have been met:~~

~~1. Stationary sources.~~

~~The source shall be designed, built and equipped to comply with standards of performance prescribed under Part V.~~

~~2. Stationary sources of hazardous air pollutants.~~

~~The source shall be designed, built and equipped to comply with emission standards prescribed under Part VI.~~

~~3. Stack elevation reductions under § 120-08-01 C 3.~~

~~The source shall be designed, built and equipped to operate without preventing or interfering with the attainment or maintenance of any applicable ambient air quality standard and without causing or exacerbating a violation of any applicable ambient air quality standard.~~

~~G.~~ *F.* Action on permit application.

1. Within 30 days after receipt of an application ~~or any additional information~~ , the board shall ~~advise~~ *notify* the applicant of ~~any deficiency in such application or information~~ *the status of the application . The notification of the initial determination with regard to the status of the application shall be provided by the board in writing and shall include (i) a determination as to which provisions of Part VIII are applicable, (ii) the identification of any deficiencies, and (iii) a determination as to whether the application contains sufficient information to begin application review. The determination that the application has sufficient information to begin review is not necessarily a determination that it is complete. Within 30 days after receipt of any additional information, the board shall notify the applicant of any deficiencies in such information.* ~~In the event that additional information is required,~~ The date of receipt of ~~the~~ *a complete* application for processing under subsection ~~G 2~~ *F 2* of this section shall be the date on which the board received all required information.

2. Processing time for a permit is normally 90 days following receipt of a complete application. ~~The board may extend this period if additional information is required.~~ Processing steps normally are as follows:

a. Completion of the preliminary review and analysis in accordance with subsection ~~L~~ *I* of this section and the preliminary decision of the board. This step may constitute the final step if ~~no public comment period or public hearing is required~~ *the provisions of subsection G of this section concerning public participation are not applicable .*

b. ~~Public comment period and public hearing, when required by subsection C 4 of this section.~~ *When required, completion of the public participation requirements in subsection G of this section.*

c. Completion of the final review and analysis and the final decision of the board.

~~3. When a public comment period or public hearing is required, the board shall notify the public, by advertisement in at least one newspaper of general circulation in the affected Air Quality Control Region, of the opportunity for public comment and the public hearing on the information available for public inspection under the provisions of subsection G 3 a of this section.~~

~~a. Information on the permit application (exclusive of confidential information under § 120-02-30), as well as the preliminary review and analysis and preliminary decision of the board, shall be available for public inspection during the entire public comment period in at least one location in the affected Air Quality Control Region.~~

~~b. A copy of the notice shall be sent to all local air pollution control agencies having State Implementation Plan responsibilities in the affected Air Quality Control Region, all states sharing the affected Air Quality Control Region, and to the Regional Administrator, U.S. Environmental Protection Agency.~~

~~4.~~ *3.* The board normally will take action on all applications after completion of the review and analysis, or expiration of the public comment period (and consideration of comments therefrom) when required, unless more information is needed. The board shall notify the applicant in writing of its decision on the application, including its reasons, and shall also specify the applicable emission limitations. These emission limitations are applicable during any emission testing conducted in accordance with subsection ~~H~~ *J* of this section.

~~5~~ *4.* The applicant may appeal the decision pursuant to § 120-02-09.

~~6.~~ *5* Within 5 days after notification to the applicant pursuant to subsection ~~G~~ 4 *F 3* of this section, the notification and any comments received pursuant to the public comment period and public hearing shall be made available for public inspection at the same location as was the information in subsection ~~G 3 a~~ *G 7 a* of this section.

G. Public participation.

1. No later than 15 days after submitting an application to the board, an applicant for a permit for a major modification with a net emissions increase of 100 tons per year of any single pollutant shall notify the public of the proposed source as

required in subsection G 2 of this section.

2. The public notice required under this subsection shall be placed by the applicant in at least one newpaper of general circulation in the affected air quality control region. The notice shall be approved by the board and shall include, but not be limited to, the following:

a. The source name, location, and type.

b. The pollutants and the total quantity of each which the applicant estimates will be emitted, and a brief statement of the air quality impact of such pollutants.

c. The control techology proposed to be used at the time of the publication of the notice.

d. The name and telephone number of a contact person employed by the applicant who can answer questions about the proposed source.

3. Upon a determination by the board that it will achieve the desired results in an equally effective manner, an applicant for a permit may implement an alternative plan for notifying the public as required in subsection G 2 of this section.

4. Prior to the decision of the board, permit applications as specified below shall be subject to a public comment period of at least 30 days. At the end of the public comment period, a public hearing shall be held in accordance with subsection G 6 of this section.

a. Applications for stationary sources of hazardous air pollutants as specified in subsection C 1 b of this section.

b. Applications for major stationary sources and major modifications with a net emissions increase of 100 tons per year of any single pollutant.

c. Applications for stationary sources which have the potential for public interest concerning air quality issues, as determined by the board. The identification of such sources shall be made using the following criteria:

(1) Whether the project is opposed by any person.

(2) Whether the project has resulted in adverse media.

(3) Whether the project has generated adverse comment through any public participation or governmental review process initiated by any other governmental agency.

(4) Whether the project has generated adverse comment by a local official, governing body or advisory board.

d. Applications for stationary sources for which any provision of the permit is to be based upon a good engineering practice (GEP) stack height that exceeds the height allowed by paragraphs 1 and 2 of the GEP definition. The demonstration specified in paragraph 3 of the GEP definition must be available during the public comment period.

5. When a public comment period and public hearing are required, the board shall notify the public, by advertisement in at least one newspaper of general circulation in the affected air quality control region, of the opportunity for the public comment and the public hearing on the information available for public inspection under the provisions of subsection G 6a of this section. The notification shall be published at least 30 days prior to the day of the public hearing.

a. Information on the permit application (exclusive of confidential information under § 120-02-30), as well as the preliminary review and analysis and preliminary decision of the board, shall be available for public inspection during the entire public comment period in at least one location in the affected air quality control region.

b. A copy of the notice shall be sent to all local air pollution control agencies having State Implemenation Plan responsibilities in the affected air quality control region, all states sharing the affected air quality control region, and to the regional administrator, U.S. Environmental Protection Agency.

H. Standards for granting permits.

No permit will be granted pursuant to this section unless it is shown to the satisfaction of the board that the source will be designed, built and equipped to operate without causing a violation of the applicable provisions of these regulations and that the following standards have been met:

1. The source shall be designed, built and equipped to comply with standards of performance prescribed under Part V and with emission standards prescribed under Part VI.

2. The source shall be designed, built and equipped to operate without preventing or interfering with the attainment or maintenance of any applicable ambient air quality standard and without causing or exacerbating a violation of any applicable ambient air quality standard.

3. Stack evaluation reductions under § 120-08-01 C 3. The source shall be designed, built and equipped to operate without preventing or interfering with the

attainment or maintenance of any applicable ambient air quality standard and without causing or exacerbating a violation of any applicable ambient air quality standard.

I. Application review and analysis.

No permit shall be granted pursuant to this section unless compliance with the standards in subsection H of this section is demonstrated to the satisfaction of the board by a review and analysis of the application performed on a source-by-source basis as specified below:

1. Stationary sources.

a. Applications for stationary sources shall be subject to a control technology review to determine if such source will be designed, built and equipped to comply with all applicable standards of performance prescribed under Part V.

b. Applications shall be subject to an air quality analysis to determine the impact of pollutant emissions as may be deemed appropriate by the board.

2. Stationary sources of hazardous air pollutants. Applications for stationary sources of hazardous air pollutants shall be subject to a control technology review to determine if such source will be designed, built and equipped to comply with all applicable emission standards prescribed under Part VI.

3. Stack elevation reductions under § 120-08-01 C 3. Applications under § 120-08-01 C 3 shall be subject to an air quality analysis to determine the impact of applicable criteria pollutant emissions.

~~H.~~ *J.* Compliance determination and verification by performance testing.

1. For stationary sources other than those specified in subsection H 2 of this section, compliance with standards of performance shall be determined in accordance with the provisions of § 120-05-02 and shall be verified by performance tests in accordance with the provisions of § 120-05-03.

2. For stationary sources of hazardous air pollutants, compliance with emission standards shall be determined in accordance with the provisions of § 120-06-02 and shall be verified by emission tests in accordance with the provisions of § 120-06-03.

3. Testing required by subsections ~~H 1 and 2~~ *J 1 and 2* of this section shall be conducted *by the owner* within 60 days after achieving the maximum production rate at which the new or modified source will be operated, but not later than 180 days after initial startup of the source; and 60 days thereafter the board shall be provided *by the owner* with two or, upon request, more copies of a written report of the results of the tests.

4. For sources subject to the provisions of Rule 5-5 or 6-1, the requirements of subsections ~~H 1 through 3~~ *J 1 through 3* of this section shall be met in all cases.

5. For sources other than those specified in subsection ~~H~~ 4 *J 4* of this section, the requirements of subsection ~~H 1 through 3~~ *J 1 through 3* of this section shall be met unless the board:

a. Specifies or approves, in specific cases, the use of a reference method with minor changes in methodology;

b. Approves the use of an equivalent method;

c. Approves the use of an alternative method, the results of which the board has determined to be adequate for indicating whether a specific source is in compliance;

d. Waives the requirement for testing because, based upon a technical evaluation of the past performance of similar source types, using similar control methods, the board reasonably excepts the new or modified source to perform in compliance with applicable standards; or

e. Waives the requirement for testing because the owner of the source has demonstrated by other means to the board's satisfaction that the source is in compliance with the applicable standard.

6. The provisions for the granting of waivers under subsection ~~H 5~~ *J 5* of this section are intended for use in determining the initial compliance status of a source, and the granting of a waiver does not obligate the board to do so for determining compliance once the source has been in operation for more than one year beyond the initial startup date.

~~I.~~ *K.* ~~Revocation of permit~~ *Permit invalidation, revocation and enforcement .*

1. A permit granted pursuant to this section shall become invalid if a program of continuous construction, reconstruction or modification is not commenced within the ~~later~~ *latest* of the following timeframes:

a. 18 months from the date the permit is granted.

b. 9 months from the date of the issuance of the last permit or other authorization (other than permits granted pursuant to this section) from any governmental entity.

c. 9 months from the date of the last resolution of

any litigation concerning any such permits or authorizations (including permits granted pursuant to this section).

2. A permit granted pursuant to this section shall become invalid if a program of construction, reconstruction or modification is discontinued for a period of 18 months or more, or if a program of construction, reconstruction or modification is not completed within a reasonable time. This provision does not apply to the period between construction of the approved phases of a phased construction project; each phase must commence construction within 18 months of the projected and approved commencement date.

3. The board may extend the periods prescribed in subsections ~~I 1 and 2~~ *K 1 and 2* of this section upon a satisfactory demonstration that an extension is justified. Provided there is no substantive change to the application information, the review and analysis, and the decision of the board, such extensions may be granted without being subject to the procedural requirements of this section.

4. Any owner who constructs or operates a new or modified source not in accordance (i) with the application submitted pursuant to this section or (ii) with the terms and conditions of any approval to construct or operate, or any owner of a new or modified source subject to this section who commences construction or operation without applying for and receiving approval hereunder, shall be subject to appropriate enforcement action.

5. Permits issued under this section shall be subject to such terms and conditions set forth in the permit as the board may deem necessary to ensure compliance with all applicable requirements of the regulations.

6. The board may revoke any permit if the permittee:

a. Knowingly makes material misstatements in the permit application or any amendments thereto;

b. Fails to comply with the terms or conditions of the permit;

c. Fails to comply with any emission standards applicable to an emissions unit included in the permit;

d. Causes emissions from the stationary source which result in violations of, or interfere with the attainment and maintenance of, any ambient air quality standard; or fails to operate in conformance with any applicable control strategy, including any emission standards or emission limitations, in the State Implementation Plan in effect at the time that an application is submitted; or

e. Fails to comply with the applicable provisions of this section.

7. The board may suspend, under such conditions and for such period of time as the board may prescribe, any permit for any of the grounds for revocation contained in subsection K 6 of this section or for any other violations of these regulations.

8. Violation of these regulations shall be grounds for revocation of permits issued under this section and are subject to the civil charges, penalties and all other relief contained in Part II of these regulations and the Virginia Air Pollution Control Law.

9. The board shall notify the applicant in writing of its decision, with its reasons, to change, suspend or revoke a permit, or to render a permit invalid.

~~J.~~ *L.* Existence of permit no defense.

The existence of a permit under this section shall not constitute defense to a violation of the Virginia Air Pollution Control Law or these regulations and shall not relieve any owner of the responsibility to comply with any applicable regulations, laws, ordinances and orders of the governmental entities having jurisdiction.

~~K.~~ *M.* Compliance with local zoning requirements.

The owner shall comply in all respects with any existing zoning ordinances and regulations in the locality in which the source is located or proposes to be located; provided, however, that such compliance does not relieve the board of its duty under § 120-02-14 of these Regulations and § 10.1-1307 E of the Virginia Air Pollution Control Law to independently consider relevant facts and circumstances.

~~L. Application review and analysis.~~

~~No permit shall be granted pursuant to this section unless compliance with the standards in subsection F of this section is demonstrated to the satisfaction of the board by a review and analysis of the application performed on a source-by-source basis as specified below:~~

~~1. Stationary sources. Application for stationary sources shall be subject to a control technology review to determine if such source will be designed, built and equipped to comply with all applicable standards of performance prescribed under Part V.~~

~~2. Stationary sources of hazardous air pollutants. Applications for stationary sources of hazardous air pollutants shall be subject to a control technology review to determine if such source will be designed, built and equipped to comply with all applicable emission standards prescribed under Part VI.~~

~~3. Stack elevation reductions under § 120-08-01 C 3. Applications under § 120-08-01 C 3 shall be subject to~~

~~an air quality analysis to determine the impact of applicable criteria pollutant emissions.~~

N. Reactivation and permanent shutdown.

1. The reactivation of a stationary source is not subject to provisions of this section unless a decision concerning shutdown has been made pursuant to the provisions of subdivisions N 2 through N 4 of this section or subdivision P 5 of § 120-08-04.

2. Upon a final decision by the board that a stationary source is shut down permanently, the board shall revoke the permit by written notification to the owner and remove the source from the emission inventory or consider its emissions to be zero in any air quality analysis conducted; and the source shall not commence operation without a permit being issued under the applicable provisions of Part VIII.

3. The final decisions shall be rendered as follows:

a. Upon a determination that the source has not operated for a year or more, the board shall provide written notification to the owner (i) of its tentative decisions that the source is considered to be shut down permanently; (ii) that the decision shall become final if the owner fails to provide, within three months of notice, written response to the board the the shutdown is not to be considered permanent; and (iii) that the owner has a right to a formal hearing on this issue before the board makes a final decision. The response from the owner shall include the basis for the assertion that the sutdown is not to be considered permanent and a projected date for restart-up of the source and shall include a request for a formal hearing if the owner wishes to exercise that right.

b. If the board should find that the basis for the assertion is not sound or the projected restart-up date allows for an unreasonably long period of inoperation, the board shall hold a formal hearing on the issue if one is requested or, if no hearing is requested, the decision to consider the shutdown permanent shall become final.

4. Nothing in these regulations shall be construed to prevent the board and the owner from making a mutual determination that a source is shutdown permanently prior to any final decision rendered under subdivision N 3 of this section.

O. Transfer of permits.

1. No persons shall transfer a permit from one location to another, or from one piece of equipment to another.

2. In the case of a transfer of ownership of a stationary source, the new owner shall abide by any current permit issued to the previous owner. The new owner shall notify the board of the change in ownership within 30 days of the transfer.

3. In the case of a name change of a stationary source, the owner shall abide by any current permit issued under the previous source name. The owner shall notify the board of the change in source name within 30 days of the name change.

4. The provisions of this subsection concerning the transfer of a permit from one location to another shall not apply to the relocation of portable facilities that are exempt from the provisions of this section by Section VII of Appendix R.

~~M.~~ *P.* Circumvention.

Regardless of the exemptions provided in this section, no owner or other person shall circumvent the requirements of this section by causing or allowing a pattern of ownership or development over a geographic area of a source which, except for the pattern of ownership or development, would otherwise require a permit.

§ 120-08-02. Permits - major stationary sources and major modifications locating in prevention of significant deterioration areas.

A. Applicability.

1. The provisions of this section apply to the construction of any major stationary source or major modification.

2. The provisions of this ~~rule~~ *section* apply in prevention of significant deterioration areas designated in Appendix L.

3. Where a source is constructed or modified in increments which individually are not subject to approval under this section and which are not part of a program of construction or modification in planned incremental phases approved by the board, all such increments shall be added together for determining the applicability of this section.

~~3.~~ *4.* Unless specified otherwise, the provisions of this section are applicable to various sources as follows:

a. Provisions referring to "sources," "new or modified sources" or "stationary sources" are applicable to the construction of all major stationary sources and major modifications.

b. Any emissions units not subject to the provisions of this section may be subject to the provisions of § 120-08-01 or § 120-08-03.

B. Definitions.

1. As used in this section, all words or terms not defined herein shall have the meaning given them in Part I, unless otherwise required by context.

2. For the purpose of this section, § 120-05-0405 and any related use, the words or terms shall have the meaning given them in subdivision B 3 of this section:

3. Terms defined.

"Actual emissions":

(1) Means the actual rate of emissions of a pollutant from an emissions unit, as determined in accordance with subdivisions 3a (2) through 3a (4) of this subsection.

(2) In general, actual emissions as of a particular date shall equal the average rate, in tons per year, at which the unit actually emitted the pollutant during a two-year period which precedes the particular date and which is representative of normal source operation. The board shall allow the use of a different time period upon a determination that it is more representative of normal source operation. Actual emissions shall be calculated using the unit's actual operating hours, production rates, and types of materials processed, stored, or combusted during the selected time period.

(3) The board may presume that source-specific allowable emissions for the unit are equivalent to the actual emissions of the unit.

(4) For any emissions unit which has not begun normal operations on the particular date, actual emissions shall equal the potential to emit of the unit of that date.

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

"Adverse impact on visibility" means visibility impairment which interferes with the management, protection, preservation or enjoyment of the visitor's visual experience of the federal class I area. This determination must be made on a case-by-case basis taking into account the geographic extent, intensity, duration, frequency and time of visibility impairment, and how these factors correlate with (i) times of visitor use of the federal class I areas, and (ii) the frequency and timing of natural conditions that reduce visibility.

"Allowable emissions" means the emissions rate of a stationary source calculated using the maximum rated capacity of the source (unless the source is subject to federally or state enforceable limits which restrict the operating rate, or hours of operation, or both) and the most stringent of the following:

(1) The applicable standards as set forth in 40 CFR Parts 60 and 61;

(2) The applicable State Implementation Plan emissions limitation including those with a future compliance date; or

(3) The emissions rate specified as a federally or state enforceable permit condition, including those with a future compliance date.

Baseline area":

(1) Means any intrastate area (and every part thereof) designated as attainment or unclassifiable under § 107(d)(1)(D) or (E) of the federal Clean Air Act in which the major source or major modification establishing the minor source baseline date would construct or would have an air quality impact equal to or greater than 1 ug/m^3 (annual average) of the pollutant for which the minor source baseline date is established.

(2) Area redesignations under § 107(d)(1)(D) or (E) of the federal Clean Air Act cannot intersect or be smaller than the area of impact of any major stationary source or major modification which:

(a) Establishes a minor source baseline date; or

(b) Is subject to this section or 40 CFR 52.21 and would be constructed in the same state as the state proposing the redesignation.

"Baseline concentration":

(1) Means that ambient concentration level which exists in the baseline area at the time of the applicable minor source baseline date. A baseline concentration is determined for each pollutant for which a baseline date is established and shall include:

(a) The actual emissions representative of sources in existence on the applicable minor source baseline date, except as provided in subdivision (2);

(b) The allowable emissions of major stationary sources which commenced construction before the major source baseline date, but were not in operation by the applicable minor source baseline date.

(2) The following will not be included in the baseline concentration and will affect the applicable maximum allowable increase(s):

(a) Actual emissions from any major stationary source on which construction commenced after the major source baseline date; and

(b) Actual emissions increases and decreases at any stationary source occurring after the minor source baseline date.

"Baseline date":

(1) "Major source baseline date" means:

(a) In the case of particulate matter and sulfur dioxide, January 6, 1975, and

(b) In the case of nitrogen dioxide, February 8, 1988.

(2) "Minor source baseline date" means the earliest date after the trigger date on which a major stationary source or a major modification subject to this section submits a complete application under this section. The trigger date is:

(a) In the case of particulate matter and sulfur dioxide, August 7, 1977, and

(b) In the case of nitrogen dioxide, February 8, 1988.

(3) The baseline date is established for each pollutant for which increments or other equivalent measures have been established if:

(a) The area in which the proposed source or modification would construct is designated as attainment or unclassifiable under § 107(d)(1)(D) or (E) of the federal Clean Air Act for the pollutant on the date of its complete application under this section or 40 CFR 52.21; and

(b) In the case of a major stationary source, the pollutant would be emitted in significant amounts, or, in the case of a major modification, there would be a significant net emissions increase of the pollutant.

"Begin actual construction" means, in general, initiation of physical on-site construction activities on an emissions unit which are of a permanent nature. Such activities include, but are not limited to, installation of building supports and foundations, laying of underground pipework, and construction of permanent storage structures. With respect to a change in method of operation, this term refers to those on-site activities other than preparatory activities which mark the initiation of the change.

"Best available control technology" means an emissions limitation (including a visible emissions standard) based on the maximum degree of reduction for each pollutant subject to regulation under the federal Clean Air Act which would be emitted from any proposed major stationary source or major modification which the board, on a case-by-case basis, taking into account energy, environmental, and economic impacts and other costs, determines is achievable for such source or modification through application of production processes or available methods, systems, and techniques, including fuel cleaning or treatment or innovative fuel combustion techniques for control of such pollutant. In no event shall application of best available control technology result in emissions of any pollutant which would exceed the emissions allowed by any applicable standard under 40 CFR Parts 60 and 61. If the board determines that technological or economic limitations on the application of measurement methodology to a particular emissions unit would make the imposition of an emissions standard infeasible, a design, equipment, work practice, operational standard, or combination thereof, may be prescribed instead to satisfy the requirement for the application of best available control technology. Such standard shall, to the degree possible, set forth the emissions reduction achievable by implementation of such design, equipment, work practice or operation, and shall provide for compliance by means which achieve equivalent results.

"Building, structure, facility or installation" means all of the pollutant-emitting activities which belong to the same industrial grouping, are located on one or more contiguous or adjacent properties, and are under the control of the same person (or persons under common control) except the activities of any vessel. Pollutant-emitting activities shall be considered as part of the same industrial grouping if they belong to the same "Major Group" (i.e., which have the same first two-digit code) as described in the Standard Industrial Classification Manual, as amended by the Supplement (see Appendix M).

"Commence," as applied to construction of a major stationary source or major modification, means that the owner has all necessary preconstruction approvals or permits and either has:

(1) Begun, or caused to begin, a continuous program of actual on-site construction of the source, to be completed within a reasonable time; or

(2) Entered into binding agreements or contractual obligations, which cannot be ~~cancelled~~ *canceled* or modified without substantial loss to the owner, to undertake a program of actual construction of the source, to be completed within a reasonable time.

"Complete" means, in reference to an application for a permit, that the application contains all of the information necessary for processing the application.

"Construction" means any physical change or change in the method of operation (including fabrication, erection, installation, demolition, or modification of an emissions unit) which would result in a change in actual emissions.

"Emissions unit" means any part of a stationary source which emits or would have the potential to emit any pollutant subject to regulation under the federal Clean Air Act.

"Federal land manager" means, with respect to any lands in the United States, the secretary of the department with authority over such lands.

"Federally enforceable" means all limitations and conditions which are enforceable by the administrator, including those requirements developed pursuant to 40 CFR Parts 60 and 61, requirements within the State Implementation Plan, and any permit requirements established pursuant to 40 CFR 52.21 or Part VIII, including operating permits issued under an EPA-approved program that is incorporated into the State Implementation Plan and expressly requires adherence to any permit issued under such program.

"Fugitive emissions" means those emissions which could not reasonably pass through a stack, chimney, vent, or other functionally equivalent opening.

"High terrain" means any area having an elevation 900 feet or more above the base of the stack of a source.

"Indian governing body" means the governing body of any tribe, band, or group of Indians subject to the jurisdiction of the United States and recognized by the United States as possessing power of self-government.

"Indian reservation" means any federally recognized reservation established by treaty, agreement, executive order, or act of Congress.

"Innovative control technology" means any system of air pollution control that has not been adequately demonstrated in practice, but would have substantial likelihood of achieving greater continuous emissions reduction than any control system in current practice or of achieving at least comparable reductions at lower cost in terms of energy, economics, or nonair quality environmental impacts.

"Low terrain" means any area other than high terrain.

"Major modification":

(1) Means any physical change in or change in the method of operation of a major stationary source that would result in a significant net emissions increase of any pollutant subject to regulation under the federal Clean Air Act.

(2) Any net emissions increase that is significant for volatile organic compounds shall be considered significant for ozone.

(3) A physical change or change in the method of operation shall not include:

(a) Routine maintenance, repair and replacement;

~~(b) Use of an alternative fuel or raw material by reason of an order under Sections 2(a) and (b) of the Energy Supply and Environmental Coordination Act of 1974 (or any superseding legislation) or by reason of a natural gas curtailment plan pursuant to the Federal Power Act;~~

~~(c) Use of an alternative fuel by reason of an order or rule under Section 125 of the federal Clean Air Act;~~

~~(d) Use of an alternative fuel at a steam generating unit to the extent that the fuel is generated from municipal solid waste;~~

~~(e)~~ *(b)* Use of an alternative fuel or raw material by a stationary source which:

1. The source was capable of accommodating before January 6, 1975, unless such change would be prohibited under any federally or state enforceable permit condition which was established after January 6, 1975, pursuant to 40 CFR 52.21 or Part VIII; or

2. The source is approved to use under any permit issued under 40 CFR 52.21 or Part VIII;

~~(f)~~ *(c)* An increase in the hours of operation or in the production rate, unless such change is prohibited under any federally or state enforceable permit condition which was established after January 6, 1975, pursuant to 40 CFR 52.21 or Part VIII ; .

~~(g) Any change in ownership at a stationary source.~~

"Major stationary source":

(1) Means:

(a) Any of the following stationary sources of air pollutants which emits, or has the potential to emit,100 tons per year or more of any pollutant subject to regulation under the federal Clean Air Act:

1 Fossil fuel-fired steam electric plants of more than 250 million British thermal units per hour heat input.

2 Coal cleaning plants (with thermal dryers).

3 Kraft pulp mills.

4 Portland cement plants.

5 Primary zinc smelters.

6 Iron and steel mill plants.

7 Primary aluminum ore reduction plants.

8 Primary copper smelters.

9 Municipal incinerators capable of charging more than 250 tons of refuse per day.

10 Hydrofluoric acid plants.

11 Sulfuric acid plants.

12 Nitric acid plants.

13 Petroleum refineries.

14 Lime plants.

15 Phosphate rock processing plants.

16 Coke oven batteries.

17 Sulfur recovery plants.

18 Carbon black plants (furnace process).

19 Primary lead smelters.

20 Fuel conversion plants.

21 Sintering plants.

22 Secondary metal production plants.

23 Chemical process plants.

24 Fossil fuel boilers (or combinations thereof) totaling more than 250 million British thermal units per hour heat input.

25 Petroleum storage and transfer units with a total storage capacity exceeding 300,000 barrels.

26 Taconite ore processing plants.

27 Glass fiber processing plants.

28 Charcoal production plants.

(b) Notwithstanding the stationary source size specified in subdivision (1)(a), stationary source which emits, or has the potential to emit, 250 tons per year or more of any air pollutant subject to regulation under the federal Clean Air Act; or

(c) Any physical change that would occur at a stationary source not otherwise qualifying under subdivision (1)(a) or (1)(b) as a major stationary source, if the change would constitute a major stationary source by itself.

(2) A major stationary source that is major for volatile organic compounds shall be considered major for ozone.

(3) The fugitive emissions of a stationary source shall not be included in determining for any of the purposes of this section whether it is a major stationary source, unless the source belongs to one of the following categories of stationary sources:

(a) Coal cleaning plants (with thermal dryers).

(b) Kraft pulp mills.

(c) Portland cement plants.

(d) Primary zinc smelters.

(e) Iron and steel mills.

(f) Primary aluminum ore reduction plants.

(g) Primary copper smelters.

(h) Municipal incinerators capable of charging more than 250 tons of refuse per day.

(i) Hydrofluoric, sulfuric, or nitric acid plants.

(j) Petroleum refineries.

(k) Lime plants.

(l) Phosphate rock processing plants.

(m) Coke oven batteries.

(n) Sulfur recovery plants.

(o) Carbon black plants (furnace process).

(p) Primary lead smelters.

(q) Fuel conversion plants.

(r) Sintering plants.

(s) Secondary metal production plants.

(t) Chemical process plants.

(u) Fossil-fuel boilers (or combination thereof) totaling more than 250 million British thermal units per hour heat input.

(v) Petroleum storage and transfer units with a total storage capacity exceeding 300,000 barrels.

(w) Taconite ore processing plants.

(x) Glass fiber processing plants.

(y) Charcoal production plants.

(z) Fossil fuel-fired steam electric plants of more that 250 million British thermal units per hour heat

input.

(aa) Any other stationary source category which, as of August 7, 1980, is being regulated under Section 111 or 112 of the federal Clean Air Act.

"Necessary preconstruction approvals or permits" means those permits or approvals required under federal air quality control laws and regulations, and those air quality control laws and regulations which are part of the applicable State Implementation Plan.

"Net emissions increase":

(1) Means the amount by which the sum of the following exceeds zero:

(a) Any increase in actual emissions from a particular physical change or change in the method of operation at a stationary source; and

(b) Any other increases and decreases in actual emissions at the source that are contemporaneous with the particular change and are otherwise creditable.

(2) An increase or decrease in actual emissions is contemporaneous with the increase from the particular change only if it occurs between:

(a) The date five years before construction on the particular change commences; and

(b) The date that the increase from the particular change occurs.

(3) An increase or decrease in actual emissions is creditable only if the board has not relied on it in issuing a permit for the source under this section (or the administrator under 40 CFR 52.21), which permit is in effect when the increase in actual emissions from the particular change occurs.

(4) An increase or decrease in actual emissions of sulfur dioxide, particulate matter, or nitrogen oxides which occurs before the applicable minor source baseline date is creditable only if it is required to be considered in calculating the amount of maximum allowable increases remaining available.

(5) An increase in actual emissions is creditable only to the extent that the new level of actual emissions exceeds the old level.

(6) A decrease in actual emission is creditable only to the extent that:

(a) The old level of actual emissions or the old level of allowable emissions, whichever is lower, exceeds the new level of actual emissions;

(b) It is federally or state enforceable at and after the time that actual construction on the particular change begins; and

(c) It has approximately the same qualitative significance for public health and welfare as that attributed to the increase from the particular change.

(7) An increase that results from a physical change at a source occurs when the emissions unit on which construction occurred becomes operational and begins to emit a particular pollutant. Any replacement unit that requires shakedown becomes operational only after a reasonable shakedown period, not to exceed 180 days.

"Potential to emit" means the maximum capacity of a stationary source to emit a pollutant under its physical and operational design. Any physical or operational limitation on the capacity of the source to emit a pollutant, including air pollution control equipment, and restrictions on hours of operation or on the type or amount of material combusted, stored, or processed, shall be treated as part of its design if the limitation or the effect it would have on emissions is federally or state enforceable. Secondary emissions do not count in determining the potential to emit of a stationary source.

"Secondary emissions" means emissions which would occur as a result of the construction or operation of a major stationary source or major modification, but do not come from the major stationary source or major modification itself. For the purpose of this section, secondary emissions must be specific, well defined, quantifiable; and impact the same general area as the stationary source or modification which causes the secondary emissions. Secondary emissions include emissions from any offsite support facility which would not be constructed or increase its emissions except as a result of the construction or operation of the major stationary source or major modification. Secondary emissions do not include any emissions which come directly from a mobile source, such as emissions from the tailpipe of a motor vehicle, from a train, or from a vessel.

"Significant":

(1) Means, in reference to a net emissions increase or the potential of a source to emit any of the following pollutants, a rate of emissions that would equal or exceed any of the following rates:

Pollutant	Emissions Rate
Carbon Monoxide	100 tons per year (tpy)
Nitrogen Oxides	40 tpy
Sulfur Dioxide	40 tpy
Particulate Matter (TSP)	25 tpy

PM10	15 tpy
Ozone	40 tpy of volatile organic compounds
Lead	0.6 tpy
Asbestos	0.007 tpy
Beryllium	0.0004 tpy
Mercury	0.1 tpy
Vinyl Chloride	1 tpy
Fluorides	3 tpy
Sulfuric Acid Mist	7 tpy
Hydrogen Sulfide (H2S)	10 tpy
Total Reduced Sulfur (including H2S)	10 tpy
Reduced Sulfur Compounds (including H2S)	10 tpy
Municipal waste combustor organics (measured as total tetra- through octa-chlorinated dibenzo-p-dioxins and dibenzofurans)	*3.5 x 10^{6} tpy*
Municpal waste combustor metals (measured as particulate matter)	*15 tpy*
Municipal waste combustor acid gases (measured as the sum of SO2 and HCl)	*40 tpy*

(2) Means, in reference to a net emissions increase or the potential of a source to emit a pollutant subject to regulation under the federal Clean Air Act that subdivision (1) does not list, any emissions rate.

(3) Notwithstanding subdivision (1), any emissions rate or any net emissions increase associated with a major stationary source or major modification, which would construct within 10 kilometers of a class I area, and have an impact on such area equal to or greater than 1 ug/m^3 (24-hour average).

"Stationary source" means any building, structure, facility, or installation which emits or may emit any air pollutant subject to regulation under the federal Clean Air Act.

~~*"Volatile organic compounds"* excludes each of the following compounds, unless the compound is subject to an emissions standard under Sections 111 or 112 of the federal Clean Air Act: methane; ethane; methylene chloride; 1,1,1 trichloroethane (methyl chloroform); trichlorotrifluoroethane (CFC-113) (Freon 113); trichlorofluoromethane (CFC-11); dichlorodifluoromethane (CFC-12); chlorodifluoromethane (CFC-22); trifluoromethane (FC-23); dichlorotetrafluoroethane (CFC-114); and chloropentafluoroethane (CFC-115); dichlorotrifluoroethane (HCFC-123); tetrafluoroethane (HFC-134a); dicloronfluoroethane (HCFC-141b); and chlorodifluoroethane (HCFC-142b).~~

C. General.

1. No owner or other person shall begin actual construction of any major stationary source or major modification without first obtaining from the board a permit to construct and operate such source.

2. No owner or other person shall relocate any emissions unit subject to the provisions of § 120-02-31 without first obtaining a permit from the board to relocate the unit.

3. Prior to the decision of the board, all permit applications will be subject to a public comment period, a public hearing will be held as provided in subsection R of this section.

4. The board may combine the requirements of and the permits for emission units within a stationary source subject to §§ 120-08-01, 120-08-02, and 120-08-03 into one permit. Likewise the board may require that applications for permits for emission units within a stationary source required by §§ 120-08-01, 120-08-02, and 120-08-03 be combined into one application.

D. Ambient air increments.

In areas designated as class I, II or III, increases in pollutant concentration over the baseline concentration shall be limited to the following:

MAXIMUM ALLOWABLE INCREASE
(micrograms per cubic meter)

Class I

Particulate matter:

TSP, annual geometric mean 5

TSP, 24-hour maximum 10

Sulfur dioxide:

Annual arithmetic mean 2

24-hour maximum 5

Three-hour maximum 25

Nitrogen dioxide:

Annual arithmetic mean 2.5

Class II

Particulate matter:

TSP, annual geometric mean 19

TSP, 24-hour maximum 37

Sulfur dioxide:

Annual arithmetic mean 20

24-hour maximum 91

Three-hour maximum 512

Nitrogen dioxide:

Annual arithmetic mean 25

Class III

Particulate matter:

TSP, annual geometric mean 37

TSP, 24-hour maximum 75

Sulfur dioxide:

Annual arithmetic mean 40

Twenty-four hour maximum 182

Three-hour maximum 700

Nitrogen dioxide:

Annual arithmetic mean 50

For any period other than an annual period, the applicable maximum allowable increase may be exceeded during one such period per year at any one location.

E. Ambient air ceilings.

No concentration of a pollutant shall exceed:

1. The concentration permitted under the national secondary ambient air quality standard, or

2. The concentration permitted under the national primary ambient air quality standard, whichever concentration is lowest for the pollutant for a period of exposure.

F. Applications.

~~1. Application for a permit shall be made in the following manner. If the applicant is a partnership, a general partner shall sign the application. If the applicant is a corporation, association or cooperative, an officer shall sign the application. If the applicant is a sole proprietorship, the proprietor shall sign the application.~~

~~2.~~ *1.* A single application is required, identifying each emission unit subject to this section. The application shall be submitted according to procedures approved by the board. However, where several units are included in one project, a single application covering all units in the project may be submitted. A separate application is required for each location.

~~3.~~ *2.* For projects with phased development, a single application may be submitted covering the entire project.

3. Any application form, report, or compliance certification submitted to the board shall be signed by a responsible official. A responsible official is defined as follows:

a. For a corporation, associatjion or cooperative, a responsible official is either (i) the president, secretary, treasurer, or a vice-president of the corporation in charge of a principal business function, or any other person who performs similar policy or decision-making functions for the corporation, or (ii) a duly authorized representative of such corporation if the representative is responsible for the overall operation of one or more manufacturing, production, or operating facilities applying for or subject to a permit and either (a) the facilities employ more than 250 persons or have gross annual sales or expenditures exceeding $25 million (in second quarter 1980 dollars), or (b) the authority to sign documents has been assigned or delegated to such representative in accordance with corporate procedures.

b. For a partnership or sole proprietorship, a responsible official is a general partner or the proprietor, respectively.

c. For a municipality, state, federal, or other public agency, a responsible official is either a principal executive officer or ranking elected official. A principal executive officer of a federal agency includes the chief executive officer having responsibility for the overall operations of a principal geographic unit ot the agency.

4. Any person signing a document under subdivision D 1 above shall make the following certification:

"I certify under penalty of law that this document and all attachments were prepared under my direction or supervision in accordance with a system designed to assure that qualified personnel properly gather and evaluate the information submitted. Based on my inquiry of the person or persons who manage the system, or those persons directly responsible for gathering and evaluating the

information, the information submitted is, to the best of my knowledge and belief, true, accurate, and complete. I am aware that there are significant penalties for submitting false information, including the possibility of fine and imprisonment for knowing violations."

5. As required under § 10.1-1321.1 of the Virginia Air Pollution Control Law, applications shall not be deemed complete unless the applicant has provided a notice from the locality in which the source is located or is to be located that the site and operation of the source are consistent with all local ordinances adopted pursuant to Chapter 11 (§ 15.1-427 et seq.) of Title 15.1 of the Code of Virginia.

G. Compliance with local zoning requirements.

The owner shall comply in all respects with any existing zoning ordinances and regulations in the locality in which the source is located or proposes to be located; provided, however, that such compliance does not relieve the board of its duty under § 120-02-14 of these regulations and § 10-17.18(e) and (f) of the Virginia Air Pollution Control Law to independently consider relevant facts and circumstances.

H. Compliance determination and verification by performance testing.

1. For stationary sources other than those specified in subdivision H 2 of this section, compliance with standards of performance shall be determined in accordance with the provisions of § 120-05-02 and shall be verified by performance tests in accordance with the provisions of § 120-05-03.

2. For stationary sources of hazardous air pollutants, compliance with emission standards shall be determined in accordance with the provisions of § 120-06-02 and shall be verified by emission tests in accordance with the provisions of § 120-06-03.

3. Testing required by subdivisions H 1 and 2 of this section shall be conducted within 60 days *by the owner* after achieving the maximum production rate at which the new or modified source will be operated, but not later than 180 days after initial startup of the source; and 60 days thereafter the board shall be provided *by the owner* with two or, upon request, more copies of a written report of the results of the tests.

4. For sources subject to the provisions of Rule 5-5 or 6-1, the requirements of subdivisions H 1 through 3 of this section shall be met in all cases.

5. For sources other than those specified in subdivision H 4 of this section, the requirements of subdivisions H 1 through 3 of this section shall be met unless the board:

a. Specifies or approves, in specific cases, the use of a reference method with minor changes in methodology;

b. Approves the use of an equivalent method;

c. Approves the use of an alternative method, the results of which the board has determined to be adequate for indicating whether a specific source is in compliance;

d. Waives the requirement for testing because, based upon a technical evaluation of the past performance of similar source types, using similar control methods, the board reasonably expects the new or modified source to perform in compliance with applicable standards; or

e. Waives the requirement for testing because the owner of the source has demonstrated by other means to the board's satisfaction that the source is in compliance with the applicable standard.

6. The provisions for the granting of waivers under subdivision H 5 of this section are intended for use in determining the initial compliance status of a source, and the granting of a waiver does not obligate the board to do so for determining compliance once the source has been in operation for more than one year beyond the initial startup date.

I. Stack heights.

1. The degree of emission limitation required for control of any air pollutant under this section shall not be affected in any manner by:

a. So much of the stack height of any source as exceeds good engineering practice, or

b. Any other dispersion technique.

2. Subdivision I 1 of this section shall not apply with respect to stack heights in existence before December 31, 1970, or to dispersion techniques implemented before then.

J. Review of major stationary sources and major modifications; source applicability and exemptions.

1. No stationary source or modification to which the requirements of subsections K through S of this section apply shall begin actual construction without a permit which states that the stationary source or modification would meet those requirements. The board has authority to issue any such permit.

2. The requirements of subsections K through S of this section shall apply to any major stationary source and any major modification with respect to each pollutant subject to regulation under the federal Clean Air Act

that it would emit, except as this section otherwise provides.

3. The requirements of subsections K through S of this section apply only to any major stationary source or major modification that would be constructed in an area designated as attainment or unclassifiable under § 107(d)(1)(D) or (E) of the federal Clean Air Act.

4. The requirements of subsections K through S of this section shall not apply to a particular major stationary source or major modification; if:

a. The source or modification would be a nonprofit health or nonprofit educational institution, or a major modification would occur at such an institution, and the governor submits a request to the administrator that it be exempt from those requirements; or

b. The source or modification would be a major stationary source or major modification only if fugitive emissions, to the extent quantifiable, are considered in calculating the potential to emit of the stationary source or modification and the source does not belong to any of the following categories:

(1) Coal cleaning plants (with thermal dryers).

(2) Kraft pulp mills.

(3) Portland cement plants.

(4) Primary zinc smelters.

(5) Iron and steel mills.

(6) Primary aluminum ore reduction plants.

(7) Primary copper smelters.

(8) Municipal incinerators capable of charging more than 250 tons of refuse per day.

(9) Hydrofluoric acid plants.

(10) Sulfuric acid plants.

(11) Nitric acid plants.

(12) Petroleum refineries.

(13) Lime plants.

(14) Phosphate rock processing plants.

(15) Coke oven batteries.

(16) Sulfur recovery plants.

(17) Carbon black plants (furnace process).

(18) Primary lead smelters.

(19) Fuel conversion plants.

(20) Sintering plants.

(21) Secondary metal production plants.

(22) Chemical process plants.

(23) Fossil-fuel boilers (or combination thereof) totaling more than 250 million British thermal units per hour heat input.

(24) Petroleum storage and transfer units with a total storage capacity exceeding 300,000 barrels.

(25) Taconite ore processing plants.

(26) Glass fiber processing plants.

(27) Charcoal production plants.

(28) Fossil fuel-fired steam electric plants of more than 250 million British thermal units per hour heat input.

(29) Any other stationary source category which, as of August 7, 1980, is being regulated under Section 111 or 112 of the Federal Clean Air Act; or

c. The source is a portable stationary source which has previously received a permit under this section, and

(1) The owner proposes to relocate the source and emissions of the source at the new location would be temporary; and

(2) The emissions from the source would not exceed its allowable emissions; and

(3) The emissions from the source would impact no class I area and no area where an applicable increment is known to be violated; and

(4) Reasonable notice is given to the board prior to the relocation identifying the proposed new location and the probable duration of operation at the new location. Such notice shall be given to the board not less than 10 days in advance of the proposed relocation unless a different time duration is previously approved by the board; or

d. The source or modification was not subject to this section, with respect to particulate matter, as in effect before July 31, 1987, and the owner:

(1) Obtained all final federal, state and local preconstruction approvals or permits necessary under Part VIII before July 31, 1987;

(2) Commenced construction within 18 months after July 31, 1987, or any earlier time required under Part VIII; and

(3) Did not discontinue construction for a period of 18 months or more and completed construction within a reasonable period of time; or

e. The source or modification was subject to this section or 40 CFR 52.21, with respect to particulate matter, as in effect before July 31, 1987, and the owner submitted an application for a permit under this section before that date, and the board subsequently determined that the application as submitted was complete with respect to the particulate matter requirements then in effect in this section. Instead, the requirements of subsections K through S of this section that were in effect before July 31, 1987, shall apply to such source or modification.

5. The requirements of subsections K through S of this section shall not apply to a major stationary source or major modification with respect to a particular pollutant if the owner demonstrates that, as to that pollutant, the source or modification is located in an area designated as nonattainment under Section 107 of the federal Clean Air Act.

6. The requirements of subsections L, N and P of this section shall not apply to a major stationary source or major modification with respect to a particular pollutant, if the allowable emissions of that pollutant from the source, or the net emissions increase of that pollutant from the modification:

a. Would impact no class I area and no area where an applicable increment is known to be violated, and

b. Would be temporary.

7. The requirements of subsections L, N and P of this section as they relate to any maximum allowable increase for a class II area shall not apply to a major modification at a stationary source that was in existence on March 1, 1978, if the net increase in allowable emissions of each pollutant subject to regulation under the federal Clean Air Act from the modification after the application of best available control technology would be less than 50 tons per year.

8. The board may exempt a stationary source or modification from the requirements of subsection N of this section with respect to monitoring for a particular pollutant if:

a. The emissions increase of the pollutant from the new source or the net emissions increase of the pollutant from the modification would cause, in any area, air quality impacts less than the following amounts:

Carbon monoxide - 575 ug/m³, 8-hour average

Nitrogen dioxide - 14 ug/m³, annual average

Total suspended particulate - 10 ug/m³, 24-hour average

PM10 - 10 ug/m³, 24-hour average

Sulfur dioxide - 13 ug/m³, 24-hour average

Ozone[1]

Lead - 0.1 ug/m³, 3-month average

Mercury - 0.25 ug/m³, 24-hour average

Beryllium - 0.001 ug/m³, 24-hour average

Fluorides - 0.25 ug/m³, 24-hour average

Vinyl chloride - 15 ug/m³, 24-hour average

Total reduced sulfur - 10 ug/m³, 1-hour average

Hydrogen sulfide - 0.2 ug/m³, 1-hour average

Reduced sulfur compounds - 10 ug/m³, 1-hour average; or

.....

[1] No de minimis air quality level is provided for ozone. However, any net increase of 100 tons per year or more of volatile organic compounds subject to this section would be required to perform an ambient impact analysis including the gathering of ambient air quality data.

.....

b. The concentrations of the pollutant in the area that the source or modification would affect are less than the concentrations listed in subdivision J 8 a of this section, or the pollutant is not listed in subdivision J 8 a of this section.

9. a. At the discretion of the board, the requirements for air quality monitoring of PM10 in subdivisions N 1 a through N 1 d of this section may not apply to a particular source or modification when the owner submits an application for a permit under this section on or before June 1, 1988, and the board subsequently determines that the application as submitted before that date was complete, except with respect to the requirements for monitoring particulate matter in subdivisions N 1 a through N 1 d.

b. The requirements for air quality monitoring of PM10 in subdivisions N 1 c and d and N 3 of this section shall apply to a particular source or

modification if the owner submits an application for a permit under this section after June 1, 1988, and no later than December 1, 1988. The data shall have been gathered over at least the period from February 1, 1988, to the date the application becomes otherwise complete in accordance with the provisions set forth under subdivision N 1 h of this section, except that if the board determines that a complete and adequate analysis can be accomplished with monitoring data over a shorter period (not to be less than four months), the data that subdivision N 1 c requires shall have been gathered over that shorter period.

10. The requirements of subdivision L 2 of this section shall not apply to a stationary source or modification with respect to any maximum allowable increase for nitrogen oxides if the owner of the source or modification submitted an application for a permit under this section before the provisions embodying the maximum allowable increase took effect as part of the applicable State Implementation Plan and the board subsequently determined that the application as submitted before that date was complete.

K. Control technology review.

1. A major stationary source or major modification shall meet each applicable emissions limitation under the State Implementation Plan and each applicable emissions standard and standard of performance under 40 CFR Parts 60 and 61.

2. A new major stationary source shall apply best available control technology for each pollutant subject to regulation under the federal Clean Air Act that it would have the potential to emit in significant amounts.

3. A major modification shall apply best available control technology for each pollutant subject to regulation under the federal Clean Air Act for which it would result in a significant net emissions increase at the source. This requirement applies to each proposed emissions unit at which a net emissions increase in the pollutant would occur as a result of a physical change or change in the method of operation in the unit.

4. For phased construction projects, the determination of best available control technology shall be reviewed and modified as appropriate at the latest reasonable time which occurs no later than 18 months prior to commencement of construction of each independent phase of the project. At such time, the owner of the applicable stationary source may be required to demonstrate the adequacy of any previous determination of best available control technology for the source.

L. Source impact analysis.

The owner of the proposed source or modification shall demonstrate that allowable emission increases from the proposed source or modification, in conjunction with all other applicable emissions increases or reductions (including secondary emissions), would not cause or contribute to air pollution in violation of:

1. Any national ambient air quality standard in any air quality control region; or

2. Any applicable maximum allowable increase over the baseline concentration in any area.

M. Air quality models.

1. All estimates of ambient concentrations required under this section shall be based on the applicable air quality models, data bases, and other requirements specified in the U.S. Environmental Protection Agency Guideline, EPA-450/2-78-027R, Guideline on Air Quality Models (see Appendix M).

2. Where an air quality impact model specified in the Guideline on Air Quality Models is inappropriate, the model may be modified or another model substituted. Such a modification or substitution of a model may be made on a case-by-case basis, or, where appropriate, on a generic basis for a specific state program. Written approval of the administrator must be obtained for any modification or substitution. In addition, use of a modified or substituted model must be subject to notice and opportunity for public comment under procedures developed in accordance with subsection R of this section.

N. Air quality analysis.

1. Preapplication analysis.

a. Any application for a permit under this section shall contain an analysis of ambient air quality in the area that the major stationary source or major modification would affect for each of the following pollutants:

(1) For the source, each pollutant that it would have the potential to emit in a significant amount;

(2) For the modification, each pollutant for which it would result in a significant net emissions increase.

b. With respect to any such pollutant for which no national ambient air quality standard exists, the analysis shall contain such air quality monitoring data as the board determines is necessary to assess ambient air quality for that pollutant in any area that the emissions of that pollutant would effect.

c. With respect to any such pollutant (other than nonmethane hydrocarbons) for which such a standard does exist, the analysis shall contain

continuous air quality monitoring data gathered for purposes of determining whether emissions of that pollutant would cause or contribute to a violation of the standard or any maximum allowable increase.

d. In general, the continuous air quality monitoring data that is required shall have been gathered over a period of at least one year and shall represent at least the year preceding receipt of the application, except that, if the board determines that a complete and adequate analysis can be accomplished with monitoring data gathered over a period shorter than one year (but not to be less than four months), the data that is required shall have been gathered over at least that shorter period.

e. For any application which becomes complete, except as to the requirements of subdivision N 1 c and d of this section, between June 8, 1981, and February 9, 1982, the data that subdivision N 1 c of this section requires shall have been gathered over at least the period from February 9, 1981 to the date the application becomes otherwise complete, except that:

(1) If the source or modification would have been major for that pollutant under 40 CFR 52.21 as in effect on June 19, 1978, any monitoring data shall have been gathered over at least the period required by those regulations.

(2) If the board determines that a complete and adequate analysis can be accomplished with monitoring data over a shorter period (not less than four months), the data that subdivision N 1 c of this section requires shall have been gathered over at least that shorter period.

(3) If the monitoring data would relate exclusively to ozone and would not have been required under 40 CFR 52.21 as in effect on June 19, 1978, the board may waive the otherwise applicable requirements of this subsection W to the extent that the applicant shows that the monitoring data would be unrepresentative of air quality over a full year.

f. The owner of a proposed stationary source or modification of volatile organic compounds who satisfies all conditions of Section IV of Appendix S to 40 CFR Part 51 may provide post-approval monitoring data for ozone in lieu of providing preconstruction data as required under subdivision N 1 of this section.

g. For any application that becomes complete, except as to the requirements of subdivision N 1 e and d pertaining to PM10, after December 1, 1988, and no later than August 1, 1989, the data that subdivision N 1 c requires shall have been gathered over at least the period from August 1, 1988, to the date the application becomes otherwise complete, except that if the board determines that a complete and adequate analysis can be accomplished with monitoring data over a shorter period (not to be less than four months), the data that subdivision N 1 c requires shall have been gathered over that shorter period.

h. With respect to any requirements for air quality monitoring of PM10 under subdivisions J 9 a and b, the owner shall use a monitoring method approved by the board and shall estimate the ambient concentrations of PM10 using the data collected by such approved monitoring method in accordance with estimating procedures approved by the board.

2. Post-construction monitoring. The owner of a major stationary source or major modification shall, after construction of the stationary source or modification, conduct such ambient monitoring as the board determines is necessary to determine the effect emissions from the stationary source or modification may have, or are having, on air quality in any area.

3. Operation of monitoring stations. The owner of a major stationary source or major modification shall meet the requirements of Appendix B to 40 CFR Part 58 during the operation of monitoring stations for purposes of satisfying subsection N of this section.

O. Source information.

The owner of a proposed source or modification shall submit all information necessary to perform any analysis or make any determination required under this section.

1. With respect to a source or modification to which subsections K, L, N and P of this section apply, such information shall include:

a. A description of the nature, location, design capacity, and typical operating schedule of the source or modification, including specifications and drawings showing its design and plant layout;

b. A detailed schedule for construction of the source or modification;

c. A detailed description as to what system of continuous emission reduction is planned for the source or modification, emission estimates, and any other information necessary to determine that best available control technology would be applied.

2. Upon request of the board, the owner shall also provide information on:

a. The air quality impact of the source or modification, including meteorological and topographical data necessary to estimate such impact; and

b. The air quality impacts, and the nature and extent of any or all general commercial, residential, industrial, and other growth which has occurred since the baseline date in the area the source or modification would affect.

P. Additional impact analyses.

1. The owner shall provide an analysis of the impairment to visibility, soils and vegetation that would occur as a result of the source or modification and general commercial, residential, industrial and other growth associated with the source or modification. The owner need not provide an analysis of the impact on vegetation having no significant commercial or recreational value.

2. The owner shall provide an analysis of the air quality impact projected for the area as a result of general commercial, residential, industrial and other growth associated with the source or modification.

3. The board may require monitoring of visibility in any federal class I area near the proposed new stationary source or major modification for such purposes and by such means as the board deems necessary and appropriate.

Q. Sources impacting federal class I areas - additional requirements.

1. Notice to federal land managers. The board shall provide written notice of any permit application for a proposed major stationary source or major modification, the emissions from which may affect a class I area, to the federal land manager and the federal official charged with direct responsibility for management of any lands within any such area. Such notification shall include a copy of all information relevant to the permit application and shall be given within 30 days of receipt and at least 60 days prior to any public hearing on the application for a permit to construct. Such notification shall include an analysis of the proposed source's anticipated impacts on visibility in the federal class I area. The board shall also provide the federal land manager and such federal officials with a copy of the preliminary determination required under subsection R of this section, and shall make available to them any materials used in making that determination, promptly after the board makes such determination. Finally, the board shall also notify all affected federal land managers within 30 days of receipt of any advance notification of any such permit application.

2. Federal land manager. The federal land manager and the federal official charged with direct responsibility for management of such lands have an affirmative responsibility to protect the air quality related values (including visibility) of such lands and to consider, in consultation with the board, whether a proposed source or modification will have an adverse impact on such values.

3. Visibility analysis. The board shall consider any analysis performed by the federal land manager, provided within 30 days of the notification required by subdivision Q 1 of this section, that shows that a proposed new major stationary source or major modification may have an adverse impact on visibility in any federal class I area. Where the board finds that such an analysis does not demonstrate to the satisfaction of the board that an adverse impact on visibility will result in the federal class I area, the board must, in the notice of public hearing on the permit application, either explain this decision or give notice as to where the explanation can be obtained.

4. Denial; impact on air quality related values. The federal land manager of any such lands may demonstrate to the board that the emissions from a proposed source or modification would have an adverse impact on the air quality-related values (including visibility) of those lands, notwithstanding that the change in air quality resulting from emissions from such source or modification would not cause or contribute to concentrations which would exceed the maximum allowable increases for a class I area. If the board concurs with such demonstration, then it shall not issue the permit.

5. Class I variances. The owner of a proposed source or modification may demonstrate to the federal land manager that the emissions from such source or modification would have no adverse impact on the air quality related values of any such lands (including visibility), notwithstanding that the change in air quality resulting from emissions from such source or modification would cause or contribute to concentrations which would exceed the maximum allowable increases for a class I area. If the federal land manager concurs with such demonstration and he so certifies, the board may, provided that the applicable requirements of this section are otherwise met, issue the permit with such emission limitations as may be necessary to assure that emissions of sulfur dioxide particulate matter, and nitrogen oxides would not exceed the following maximum allowable increases over minor source baseline concentration for such pollutants:

MAXIMUM ALLOWABLE INCREASE
(micrograms per cubic meter)

Particulate matter:

TSP, annual geometric mean 19

TSP, 24-hour maximum 37

Sulfur dioxide:

Annual arithmetic mean 20

24-hour maximum 91

Three-hour maximum 325

Nitrogen dioxide:

Annual arithmetic mean 25

6. Sulfur dioxide variance by governor with federal land manager's concurrence. The owner of a proposed source or modification which cannot be approved under subdivision Q 5 of this section may demonstrate to the governor that the source cannot be constructed by reason of any maximum allowable increase for sulfur dioxide for a period of 24 hours or less applicable to any class I area and, in the case of federal mandatory class I areas, that a variance under this clause would not adversely affect the air quality related values of the area (including visibility). The governor, after consideration of the federal land manager's recommendation (if any) and subject to his concurrence, may, after notice and public hearing, grant a variance from such maximum allowable increase. If such variance is granted, the board shall issue a permit to such source or modification pursuant to the requirements of subdivision Q 8, provided that the applicable requirements of this section are otherwise met.

7. Variance by the governor with the president's concurrence. In any case whether the governor recommends a variance in which the federal land manager does not concur, the recommendations of the governor and the federal land manager shall be transmitted to the president. The president may approve the governor's recommendation if he finds that the variance is in the national interest. If the variance is approved, the board shall issue a permit pursuant to the requirements of subdivision Q 8 of this section, provided that the applicable requirements of this section are otherwise met.

8. Emission limitations for presidential or gubernatorial variance. In the case of a permit issued pursuant to subdivision Q 6 or 7 of this section the source or modification shall comply with such emission limitations as may be necessary to assure that emissions of sulfur dioxide from the source or modification would not (during any day on which the otherwise applicable maximum allowable increases are exceeded) cause or contribute to concentrations which would exceed the following maximum allowable increases over the baseline concentration and to assure that such emissions would not cause or contribute to concentrations which exceed the otherwise applicable maximum allowable increases for periods of exposure of 24 hours or less for more than 18 days, not necessarily consecutive, during any annual period:

MAXIMUM ALLOWABLE INCREASE
(micrograms per cubic meter)

Period of exposure	Low terrain areas	High terrain areas
24-hour maximum	36	62
3-hour maximum	130	221

R. Public participation.

1. Within 30 days after receipt of an application ~~to construct, or any addition to such application,~~ the board shall ~~advise~~ *notify* the applicant of ~~any deficiency in the application or in the information submitted~~ *the status of the application . The notification of the initial determination with regard to the status of the application shall be provided by the board in writing and shall include (i) a determination as to which provisions of Part VIII are applicable, (ii) the identification of any deficiencies, and (iii) a determination as to whether the application contains sufficient information to begin application review. The determination that the application has sufficient information to begin review is not necessarily a determination that it is complete. Within 30 days after receipt of any additional information, the board shall notify the applicant of any deficiencies in such information.* ~~In the event of such a deficiency,~~ The date of receipt of ~~the~~ *a complete* application shall be, for the purpose of this section, the date on which the board received all required information.

2. No later than 45 days after receiving the initial determination notification required under subdivision R 1 of this section, applicants shall notify the public about the proposed source as required in subdivision R 3 of this section. The applicant shall also provide an informational briefing about the proposed source for the public as required in subdivision R 4 of this section.

3. The public notice required under subdivison R 2 of this section shall be placed by the applicant in at least one newspaper of general circulation in the affected air quality control region. The notice shall be approved by the board and shall include, but not be limited to, the name, location, and type of the source, and the time and place of the information briefing.

4. The informational briefing shall be held in the locality where the source is or will be located and at least 30 days, but no later than 60 days, following the day of the publication of the public notice in the newspaper. The applicant shall inform the public about the operation and potential air quality impact of the source and answer any questions concerning air quality about the proposed source from those in attendance at the briefing. At a minimum, the applicant shall provide information on and answer

questions about (i) specific pollutants and the total quantity of each which the applicant estimates will be emitted and (ii) the control technology proposed to be used at the time of the informational briefing. Representatives from the board shall attend and provide information and answer questions on the permit application review process.

5. Upon a determination by the board that it will achieve the desired results in an equally effective manner, an applicant for a permit may implement an alternative plan for notifying the public as required in subdivision R 3 of this subdivision R 3 of this section and for providing the informational briefing as required in subdivision R 4 of this section.

~~2.~~ *6.* Within one year after receipt of a complete application, the board shall make a final determination on the application. This involves performing the following actions in a timely manner:

a. Make a preliminary determination whether construction should be approved, approved with conditions, or disapproved.

b. Make available in at least one location in each air quality control region in which the proposed source or modification would be constructed a copy of all materials the applicant submitted, a copy of the preliminary determination and a copy or summary of other materials, if any, considered in making the preliminary determination.

c. If appropriate, hold a public briefing on the preliminary determination prior to the public comment period but no later than the day before the beginning of the public comment period. The board shall notify the public of the time and place of the briefing, by advertisement in a newspaper of general circulation in the air quality control region in which the proposed source or modification would be constructed. The notification shall be published at least 30 days prior to the day of the briefing.

~~c.~~ *d.* Notify the public, by advertisement in a newspaper of general circulation in each region in which the proposed source or modification would be constructed, of the application, the preliminary determination, the degree of increment consumption that is expected from the source or modification, and the opportunity for comment at a public hearing as well as written public comment. The notification shall be *published* at least 30 days prior to the day of the hearing.

~~d.~~ *e.* Send a copy of the notice of public comment to the applicant, the administrator and to officials and agencies having cognizance over the location where the proposed construction would occur as follows: state and local air pollution control agencies, the chief executives of the city and county where the source or modification would be located, any comprehensive regional land use planning agency and any state, federal land manager, or indian governing body whose lands may be affected by emissions from the source or modification.

~~e.~~ *f.* Provide opportunity for a public hearing for interested persons to appear and submit written or oral comments on the air quality impact of the source or modification, alternatives to the source or modification, the control technology required, and other appropriate considerations.

~~f.~~ *g.* Consider all written comments submitted within a time specified in the notice of public comment and all comments received at any public hearing(s) in making a final decision on the approvability of the application. No later than 10 days after the close of the public comment period, the applicant may submit a written response to any comments submitted by the public. The board shall consider the applicant's response in making a final decision. The board shall make all comments available for public inspection in the same locations where the board made available preconstruction information relating to the proposed source or modification.

~~g.~~ *h.* Make a final determination whether construction should be approved, approved with conditions, or disapproved pursuant to this section.

~~h.~~ *i.* Notify the applicant in writing of the final determination and make such notification available for public inspection at the same location where the board made available preconstruction information and public comments relating to the source or modification.

S. Source obligation.

1. Any owner who constructs or operates a source or modification not in accordance *(i)* with the application submitted pursuant to this section or *(ii)* with the terms *and conditions* of any approval to construct *or operate* , or any owner of a source or modification subject to this section who commences construction *or operation* after the effective date of these regulations without applying for and receiving approval hereunder, shall be subject to appropriate enforcement action *as required under subsection Z of this section* .

2. Approval to construct shall become invalid if construction is not commenced within 18 months after receipt of such approval, if construction is discontinued for a period of 18 months or more, or if construction is not completed within a reasonable time. The board may extend the 18-month period upon a satisfactory showing that an extension is justified. This provision does not apply to the time period between construction of the approved phases of a phased construction project; each phase must

commence construction within 18 months of the projected and approved commencement date.

3. Approval to construct shall not relieve any owner of the responsibility to comply fully with applicable provisions of the State Implementation Plan and any other requirements under local, state or federal law.

4. At such time that a particular source or modification becomes a major stationary source or major modification solely by virtue of a relaxation in any enforceable limitation which was established after August 7, 1980, on the capacity of the source or modification otherwise to emit a pollutant, such as a restriction on hours of operation, then the requirements of subsections K through S of this section shall apply to the source or modification as though construction had not yet commenced on the source or modification.

T. Environmental impact statements.

Whenever any proposed source or modification is subject to action by a federal agency which might necessitate preparation of an environmental impact statement pursuant to the National Environmental Policy Act (42 U.S.C. 4321), review conducted pursuant to this section shall be coordinated by the administrator with the broad environmental reviews under that Act and under Section 309 of the federal Clean Air Act to the maximum extent feasible and reasonable.

U. Disputed permits.

If a permit is proposed to be issued for any major stationary source or major modification proposed for construction in any state which the governor of an affected state or indian governing body of an affected tribe determines will cause or contribute to a cumulative change in air quality in excess of that allowed in this part within the affected state or indian reservation, the governor or indian governing body may request the administrator to enter into negotiations with the parties involved to resolve such dispute. If requested by any state or indian governing body involved, the administrator shall make a recommendation to resolve the dispute and protect the air quality related values of the lands involved. If the parties involved do not reach agreement, the administrator shall resolve the dispute and his determination, or the results of agreements reached through other means, shall become part of the applicable state implementation plan and shall be enforceable as part of such plan.

V. Interstate pollution abatement.

1. The owner of each source or modification, which may significantly contribute to levels of air pollution in excess of an ambient air quality standard in any air quality control region outside the Commonwealth, shall provide written notice to all nearby states of the air pollution levels which may be affected by such source at least 60 days prior to the date of commencement of construction.

2. Any state or political subdivision may petition the administrator for a finding that any source or modification emits or would emit any air pollutant in amounts which will prevent attainment or maintenance of any ambient air quality standard or interfere with measures for the prevention of significant deterioration or the protection of visibility in the state implementation plan for such state. Within 60 days after receipt of such petition and after a public hearing, the administrator will make such a finding or deny the petition.

3. Notwithstanding any permit granted pursuant to this section, no owner or other person shall commence construction or modification or begin operation of a source to which a finding has been made under the provisions of subdivision V 2 of this section.

W. Innovative control technology.

1. An owner of a proposed major stationary source or major modification may request the board in writing no later than the close of the public comment period under subsection R to approve a system of innovative control technology.

2. The board shall determine that the source or modification may employ a system of innovative control technology, if:

a. The proposed control system would not cause or contribute to an unreasonable risk to public health, welfare, or safety in its operation or function;

b. The owner agrees to achieve a level of continuous emissions reduction equivalent to that which would have been required under subdivision K 2 of this section by a date specified by the board. Such date shall not be later than four years from the time of startup or seven years from permit issuance;

c. The source or modification would meet the requirements of subsections K and L of this section based on the emissions rate that the stationary source employing the system of innovative control technology would be required to meet on the date specified by the board;

d. The source or modification would not, before the date specified by the board:

(1) Cause or contribute to a violation of an applicable national ambient air quality standard; or

(2) Impact any area where an applicable increment is known to be violated;

e. All other applicable requirements including those for public participation have been met; and

f. The provisions of subsection Q of this section (relating to class I areas) have been satisfied with respect to all periods during the life of the source or modification.

3. The board shall withdraw any approval to employ a system of innovative control technology made under this section, if:

a. The proposed system fails by the specified date to achieve the required continuous emissions reduction rate; or

b. The proposed system fails before the specified date so as to contribute to an unreasonable risk to public health, welfare, or safety; or

c. The board decides at any time that the proposed system is unlikely to achieve the required level of control or to protect the public health, welfare, or safety.

4. If a source or modification fails to meet the requirement level of continuous emission reduction within the specified time period or the approval is withdrawn in accordance with subdivision W 3 of this section, the board may allow the source or modification up to an additional three years to meet the requirement for the application of best available control technology through use of a demonstrated system of control.

X. Reactivation and permanent shutdown.

1. The reactivation of a stationary source is not subject to provisions of this section unless a decision concerning shutdown has been made pursuant to the provisions of subdivisions X 2 through X 4 of this section or subdivision P 5 of § 120-08-04.

2. Upon a final decision by the board that a stationary source is shut down permanently, the board shall revoke the permit by written notification to the owner and remove the source from the emission inventory or consider its emissions to be zero in any air quality analysis conducted; and the source shall not commence operation without a permit being issued under the applicable provisions of Part VIII.

3. The final decision shall be rendered as follows:

a. Upon a determination that the source has not operated for a year or more, the board shall provide written notification to the owner (i) of its tentative decision that the source is considered to be shut down permanently; (ii) that the decision shall become final if the owner fails to provide, within three months of the notice, written response to the board that the shutdown is not to be considered permanent; and (iii) that the owner has a right to a formal hearing on this issue before the board makes a final decision. The response from the owner shall include the basis for the assertion that the shutdown is not to be considered permanent and a projected date for restart-up of the source and shall include a request for a formal hearing if the owner wishes to exercise that right.

b. If the board should find that the basis for the assertion is not sound or the projected restart-up date allows for an unreasonably long period of inoperation, the board shall hold a formal hearing on the issue if one is requested or, if no hearing is requested, decision to consider the shutdown permanent shall become final.

4. Nothing in these regulations shall be construed to prevent the board and the owner from making a mutual determination that a source is shut down permanently prior to any final decision rendered under subdivision X 3 of this section.

Y. Transfer of permits.

1. No person shall transfer a permit from one location to another, or from one piece of equipment to another.

2. In the case of a transfer of ownership of a stationary source, the new owner shall abide by any current permit issued to the previous owner. The new owner shall notify the board of the change in ownership within 30 days of the transfer.

3. In the case of a name change of a stationary source, the owner shall abide by any current permit issued under the previous source name. The owner shall notify the board of the change in source name within 30 days of the name change.

4. The provisions of this subsection concerning the transfer of a permit from one location to another should not apply to the relocation of portable facilities that are exempt from the provisions of subsections K through S of this section by subdivision J 4 c of this section.

Z. Permit invalidation, revocation, and enforcement.

1. Permits issued under this section shall be subject to such terms and conditions set forth in the permit as the board may deem necessary to ensure compliance with all applicable requirements of the regulations.

2. The board may revoke any permit if the permittee:

a. Knowingly makes material misstatements in the

permit application or any amendments thereto;

b. Fails to comply with the terms or conditions of the permit;

c. Fails to comply with any emission standards applicable to an emissions unit included in the permit;

d. Causes emissions from the stationary source which result in violations of, or interfere with the attainment and maintenance of, any ambient air quality standard; or fails to operate in conformance with any applicable control strategy, including any emission standards or emision limitations, in the State Implementation Plan in effect at the time that an application is submitted; or

e. Fails to comply with the applicable provisions of this section.

3. The board may suspend, under such conditions and for such period of time as the board may prescribe, any permit for any of the grounds for revocation contained in subdivision Z 2 of this section or for any other violations of these regulations.

4. Violation of these regulations shall be grounds for revocation of permits issued under this section and are subject to the civil charges, penalties and all other relief contained in Part II of these regulations and the Virginia Air Pollution Control Law.

5. The board shall notify the applicant in writing of its decision, with its reasons, to change, suspend or revoke a permit, or to render a permit invalid.

AA. Circumvention.

Regardless of the exemptions provided in this section, no owner or other person shall circumvent the requirements of this section by causing or allowing a pattern of ownership or development over a geographic area of a source which, except for the pattern of ownership or development, would otherwise require a permit.

§ 120-08-03. Permits - major stationary sources and major modifications locating in nonattainment areas.

A. Applicability.

1. The provisions of this section apply to the construction or reconstruction of any major stationary source or major modification.

2. The provisions of this ~~rule~~ *section* apply in nonattainment areas.

3. At such time that a particular source or modification becomes a major stationary source or major modification solely by virtue of a relaxation in any enforceable limitation which was established after August 7, 1980, on the capacity of the source or modification otherwise to emit a pollutant, such as a restriction on hours of operation, then the requirements of this section shall apply to the source or modification as though construction has not commenced on the source or modification.

4. Where a source is constructed or modified in increments which individually are not subject to approval under this section and which are not part of a program of construction or modification in planned incremental phases approved by the board, all such increments shall be added together for determining the applicability of this section.

~~4.~~ *5.* Unless specified otherwise, the provisions of this section are applicable to various sources as follows:

a. Provisions referring to "sources," "new and/or modified sources" or "stationary sources" are applicable to the construction, reconstruction or modification of all major stationary sources and major modifications.

b. Any emissions units not subject to the provisions of this section may be subject to the provisions of § 120-08-01 or § 120-08-02.

B. Definitions.

1. As used in this section, all words or terms not defined herein shall have the meaning given them in Part I, unless otherwise required by context.

2. For the purpose of this section, § 120-05-0404 and any related use, the words or terms shall have the meaning given them in subsection B 3 of this section:

3. Terms defined.

"Actual emissions"

(1) Means the actual rate of emissions of a pollutant form an emissions unit, as determined in accordance with subdivisions (2) through (4).

(2) In general, actual emissions as of a particular date shall equal the average rate, in tons per year, at which the unit actually emitted the pollutant during a two-year period which precedes the particular date and which is representative of normal source operation. The board shall allow the use of a different time period upon a determination that it is more representative of normal source operation. Actual emissions shall be calculated using the unit's actual operating hours, production rates, and types of materials processed, stored, or combusted during the selected time period.

(3) The board may presume that the source-specific allowable emissions for the unit are equivalent to the actual emissions of the unit.

(4) For any emissions unit which has not begun normal opertions on the particular date, actual emissions shall equal the potential to emit of the unit of that date.

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

"Allowable emissions" means the emissions rate of a stationary source calculated using the maximum rated capacity of the source (unless the source is subject to federally or state enforceable limits which restrict the operating rate, or hours of operation, or both) and the most stringent of the following:

(1) The applicable standards set forth in 40 CFR Parts 60 and 61;

(2) Any applicable State Implementation Plant emissions limitation including those with a future compliance date; or

(3) The emissions rate specified as a federally and state enforceable permit condition, including those with a future compliance date.

"Begin actual construction" means, in general, initiation of physical onsite construction activities on an emissions unit which are of a permanent nature. Such activities include, but are not limited to, installation of building supports and foundations, laying of underground pipework, and construction of permanent storage structures. With respect to a change in method of operation, this term refers to those on-site activities other than preparatory activities which mark the initiation of the change.

"Building, structure, ~~or~~ facility, or installation" means all of the pollutant-emitting activities which belong to the same industrial grouping, are located on one or more contiguous or adjacent properties, and are under the control of the same person (or persons under common control) except the activities of any vessel. Pollutant-emitting activities shall be considered as part of the same industrial grouping if they belong to the same "Major Group" (i.e., which have the same two-digit code) as described in the "Standard Industrial Classification Manual," as amended by the Supplement (see Appendix M).

"Commence," as applied to construction of a major stationary source or major modification, means that the owner has all necessary preconstruction approvals or permits and either has:

(1) Begun, or caused to begin, a continuous program of actual on-site construction of the source, to be completed within a reasonable time; or

(2) Entered into binding agreements or contractual obligations, which cannot be ~~cancelled~~ *canceled* or modified without substantial loss to the owner, to undertake a program of actual construction of the source, to be completed within a reasonable time.

"Construction" means any physical change or change in the method of operation (including fabrication, erection, installation, demolition, or modification of an emissions unit) which would result in a change in actual emissions.

"Emissions unit" means any part of a stationary source which emits or would have the potential to emit any pollutant subject to regulation under the Federal Clean Air Act.

"Federally enforceable" means all limitations and conditions which are enforceable by the Administrator, including those requirements developed pursuant to 40 CFR Parts 60 and 61, requirements within the State Implementation Plan, and any permit requirements established pursuant to 40 CFR 52.21 or Part VIII , *including operating permits issued under an EPA-approved program that is incorporated into the State Implementation Plan and expressly requires adherence to any permit issued under such program* .

"Fixed capital cost" means the capital needed to provide all the depreciable components.

"Fugitive emissions" means those emissions which could not reasonably pass through a stack, chimney, vent, or other functionally equivalent opening.

~~"Installation" means an identifiable piece of process equipment.~~

"Lowest achievable emission rate" means for any source, the more stringent rate of emissions based on the following:

(1) The most stringent emissions limitation which is contained in the implementation plan of any state for such class or category of stationary source, unless the owner of the proposed stationary source demonstrates that such limitations are not achievable; or

(2) The most stringent emissions limitation which is achieved in practice by such class or category of stationary ~~source~~ *sources* . This limitation, when applied to a modification, means the lowest achievable emissions rate for the new or modified emissions units within the stationary source. In no event shall the application of this term permit a proposed new or modified stationary source to emit any pollutant in excess of the amount allowable under an applicable new source standard of performance.

"Major modification"

(1) Means any physical change in or change in the method of operation of a major stationary source that would result in a significant net emissions increase of any pollutant subject to regulation under the Federal Clean Air Act.

(2) Any net emissions increase that is considered significant for volatile organic compounds shall be considered significant for ozone.

(3) A physical change or change in the method of operation shall not include:

(a) Routine maintenance, repair and replacement;

~~(b) Use of an alternative fuel or rew material by reason of an order under Sections 2(a) and (b) of the Energy Supply and Environmental Coordination Act of 1974 (or any superseding legislation) or by reason of a natural gas curtailment plan pursuant to the Federal Power Act;~~

~~(c) Use of an alternative fuel by reason of an order or rule under Section 125 of the Federal Clean Air Act;~~

~~(d) Use of an alternative fuel at a steam generating unit to the extent that the fuel is generated from municipal solid waste;~~

~~(e)~~ *(b)* Use of an alternative fuel or raw material by a stationary source which:

1 The source was capable of accommodating before December 21, 1976, unless such change would be prohibited under any federally or state enforceable permit condition which was established after December 21, 1976, pursuant to 40 CFR 52.21 or Part VIII; or

2 The source is approved to use under any permit issued under 40 CFR 52.21 or Part VIII;

~~(f)~~ *(c)* An increase in the hours of operation or in the production rate, unless such change is prohibited under any federally or state enforceable pemirt conditiion which was established after December 21, 1976, pursuant to 40 CFR 52.21 or Part VIII.

~~(g) Any change in ownership at a stationary source.~~

"Major stationary source"

(1) Means:

(a) Any stationary source of air pollutants which emits, or has the potential to emit, *(i)* 100 tons per year or more of any pollutant subject to regulation under the Federal Clean Air Act , *or (ii) 50 tons per year or more of volatile organic compounds or nitrogen oxides in ozone nonattainment areas classified as serious in Apendix K, or (iii) 25 tons per year or more of volatile organic compounds or nitrogen oxides in ozone nonattainment areas classified as severe in Appendix K* ; or

(b) Any physical change that would occur at a stationary source not qualifying under subdivision ~~(a)(1)~~ *(1)(a) of this definition* as a major stationary source, if the change would constitute a major stationary source by itself.

(2) A major stationary source that is major for volatile organic compounds shall be considered major for ozone.

(3) The fugitive emissions of a stationary source shall not be included in determining for any of the purposes of this section whether it is a major stationary source, unless the source belongs to one of the following categories of stationary sources:

(a) Coal cleaning plants (with thermal dryers).

(b) Kraft pulp mills.

(c) Portland cement plants.

(d) Primary zinc smelters.

(e) Iron and steel mills.

(f) Primary aluminum ore reduction plants.

(g) Primary copper smelters.

(h) Municipal incinerators (or combinations thereof) capable of charging more than 250 tons of refuse per day.

(i) Hydrofluoric acid plants.

(j) Sulfuric acid plants.

(k) Nitric acid plants.

(l) Petroleum refineries.

(m) Lime plants.

(n) Phosphate rock processing plants.

(o) Coke oven batteries.

(p) Sulfur recovery plants.

(q) Carbon black plants (furnace process).

(r) Primary lead smelters.

(s) Fuel conversion plants.

(t) Sintering plants.

(u) Secondary metal production plants.

(v) Chemical process plants.

(w) Fossil-fuel boilers (or combination thereof) totaling more than 250 million British thermal units per hour heat input.

(x) Petroleum storage and transfer units with a total storage capacity exceeding 300,000 barrels.

(y) Taconite ore processing plants.

(z) Glass fiber manufacturing plants.

(aa) Charcoal production plants.

(bb) Fossil fuel steam electric plants of more than 250 million British thermal units per hour heat input.

(cc) Any other stationary source category which, as of August 7, 1980, is being regulated under Section 111 or 112 of the federal Clean Air Act.

"Necessary preconstruction approvals or permits" means those permits or approvals required under federal air quality control laws and regulations, and those air quality control laws and regulations which are part of the applicable State Implementation Plan.

"Net emissions increase"

(1) Means the amount by which the sum of the following exceeds zero:

(a) Any increase in actual emissions from a particular physical change or change in the method of operation at a stationary source; and

(b) Any other increases and decreases in actual emissions at the source that are contemporaneous with the particular change and are otherwise creditable.

(2) An increase or decrease in actual emissions is contemporaneous with the increase from the particular change only if it occurs before the date that the increase from the particular change occurs. *For sources located in ozone nonattainment areas classified as serious or severe in Appendix K, an increase or decrease in actual emissions of volatile organic compounds or nitrogen oxides is contemporaneous with the increase from the particular change only if it occurs during any period of five consecutive calendar years which includes the calendar year in which the increase from the particular change occurs.*

(3) An increase or decrease in actual emissions is creditable only if:

(a) It occurs ~~within a reasonable period to be specified by the board~~ *between the date five years before construction on the change specified in subdivision (1) (a) of this definition commences and the date that the increase specified in subdivision (1)(a) of this definition occurs* ; and

(b) The board has not relied on it in issuing a pemit for the source pursuant to Part VIII which permit is in effect when the increase in actual emissions from the particular change occurs.

(4) An increase in actual emissions is creditable only to the extent that the new level of actual emissions exceeds the old level.

(5) A decrease in actual emission is creditable only to the extent that:

(a) The old level of actual emissions or the old level of allowable emissions, whichever is lower, exceeds the new level of actual emissions;

(b) It is federally or state enforceable at and after the time that actual construction on the particular

(c) The board has not relied on it in issuing any permit pursuant to Part VIII or the board has not relied on it in demonstrating attainment or reasonable further progress in the State Implementation Plan.

(d) It has approximately the same qualitative significance for public health and welfare as that attributed to the increase from the particular change.

(6) An increase that results from a physical change at a source occurs when the emissions unit on which construction occurred becomes operational and begins to emit a particular pollutant. Any replacement unit that requires shakedown becomes operational only after a reasonable shakedown period, not to exceed 180 days.

"Nonattainment pollutant" means within an nonattainment area, the pollutant for which such area is designated nonattainment. For ozone nonattainment areas, the nonattainment ~~pollutant~~ *pollutants* shall be volatile organic compounds (including hydrocarbons) *and nitrogen oxides* .

"Potential to emit" means the maximum capacity of a stationary source to emit a pollutant under its physical and operational design. Any physical or operational limitation on the capacity of the source to emit a pollutant, including

air pollution control equipment, and restrictions on hours of operation or on the type or amount of material combusted, stored, or processed, shall be treated as part of its design only if the limitation or the effect it would have on emissions is federally or state enforceable. Secondary emissions do not count in determining the potential to emit of a stationary source.

"Qualifying pollutant" means with regard to a major stationary source, any pollutant emitted in such quantities or at such rate as to qualify the source as a major stationary source.

"Reasonable further progress" means the annual incremental reductions in emissions of a given air pollutant (including substantial reductions in the early years following approval or promulgation of a state implementation plan and regular reductions thereafter) which are sufficient in the judgment of the board to provide for attainment of the applicable ambient air quality standard within a specified nonattainment area by the attainment date prescribed in the State Implementation Plan for such area.

"Reconstruction" means when the fixed capital cost of the new components exceeds 50% of the fixed capital cost of a comparable entirely new stationary source. Any final decision as to whether reconstruction has occurred shall be made in accordance with the provisions of subdivisions (1) through (3) below. A reconstructed stationary source will be treated as a new stationary source for purposes of this section. In determining lowest achievable emission rate for a reconstructed stationary source, the provisions of subdivision (4) below shall be taken into account in assessing whether a new source performance standard is applicable to such stationary source.

(1) The fixed capital cost of the replacements in comparison to the fixed capital cost that would be required to construct a comparable entirely new facility.

(2) The estimated life of the facility after the replacements compared to the life of a comparable entirely new facility.

(3) The extent to which the components being replaced cause or contribute to the emissions from the facility.

(4) Any economic or technical limitations on compliance with applicable standards of performance which are inherent in the proposed replacements.

"Secondary emissions" means emissions which would occur as a result of the construction or operation of a major stationary source or major modification, but do not come from the major stationary source or major modification itself. For the purpose of this section, secondary emissions must be specific, well defined, quantifiable, and impact the same general area as the stationary source or modification which causes the secondary emissions. Secondary emissions include emissions from any offsite support facility which would not be constructed or increase its emissions except as a result of the construction or operation of the major stationary source or major modification. Secondary emissions do not include any emissions which come directly from a mobile source, such as emissions from the tailpipe of a motor vehicle, from a train, or from a vessel.

"Significant" means in reference to a net emissions increase or the potential of a source to emit any of the following pollutants, a rate of emissions that would equal or exceed any of the following rates:

(1) Ozone nonattainment areas classified as serious or severe in Appendix K.

Pollutant	*Emissions Rate*
Carbon Monoxide	*100 tons per year (tpy)*
Nitrogen Oxides	*25 tpy*
Sulfer Dioxide	*40 tpy*
Particulate Matter	*25 tpy*
Ozone	*25 tpy of volatile organic compounds*
Lead	*0.6 tpy*

(2) Other nonattainment areas.

Pollutant	Emissions Rate
Carbon Monoxide	100 tons per year (tpy)
Nitrogen Oxides	40 tpy
Sulfur Dioxide	40 tpy
Particulate Matter	25 tpy
Ozone	40 tpy of volatile organic compounds
Lead	0.6 tpy

"Stationary source" means any building, structure, facility, or installation which emits or may emit any air pollutant subject to regulation under the Federal Clean Air Act.

C. General.

1. No owner or other person shall begin actual construction, reconstructoin or modification of nay major stationary source or major modification without first obtaining from the board a permit to construct and operate such source.

2. No owner or other person shall relocate any emissions unit subject to the provisions of § 120-02-31 without first obtaining from the board a permit to relocate the unit.

~~3. Prior to the decision of the board, all permit applications will be subject to a public comment period of at least 30 days. In addition, at the end of the public comment period, a public hearing will be held with notice in accordance with subsection G 3 of this section.~~

3. The board may combine the requirements of and the permits for emission units within a stationary source subject to §§ 120-08-01, 120-08-02 and 120-08-03 into one permit. Likewise the board may require that applications for permits for emission units within a stationary source required by §§ 120-08-01, 120-08-02, and 120-08-03 be combined into one application.

D. Applications.

~~1. Application for a permit shall be made in the following manner. If the applicant is a partnership, a general partner shall sign the application. If the applicant is a corporation, association or cooperative, an officer shall sign the application. If the applicant is a sole proprietorship, the proprietor shall sign the application.~~

~~2.~~ *1.* A single application is required identifying each emission unit subject to this section. The application shall be submitted according to procedures approved by the board. However, where several units are included in one project, a single application covering all units in the project may be submitted. A separate application is required for each location.

~~3.~~ *2.* For projects with phased development, a single application should be submitted covering the entire project.

3. Any application form, report, or compliance certification submitted to the board shall be signed by a responsible official. A responsible official. A responsible official is defined as follows:

a. For a corporation, association or cooperative, a responsible official is either (i) the president, secretary, treasurer, or a vice-president of the corporation in charge of a principal business function, or any other person who performs similar policy or decision-making functions for the corporation, or (ii) a duly authorized representative of such corporation if the representative is responsible for the overall operation of one or more manufacturing, production, or operating facilities applying for or subject to a permit and either (a) the facilities employ more than 250 persons or have gross annual sales or expenditures exceeding $25 million (in second quarter 1980 dollars), or (b) the authority to sign documents has been assigned or delegated to such representative in accordance with corporate procedures.

b. For a partnership or sole proprietorship, a responsible official is a general partner or the proprietor, respectively.

c. For a municipality, state, federal, or other public agency, a responsible official is either a principal executive officer or ranking elected official. A principal executive officer of a federal agency includes the chief executive officer having responsibility for the overall operations of a principal geographic unit of the agency.

4. Any person signing a document under subdivision D 3 above shall make the following certification:

"I certify under the penalty of law that this document and all attachments were prepared under my direction or supervision in accordance with a system designed to assure that qualified personnel properly gather and evaluate the information submitted. Based on my inquiry of the person or persons who manage the system, or those persons directly responsible for gathering and evaluating the information, the information submitted is, to the best of my knowledge and belief, true, accurate, and complete. I am aware that there are significant penalties for submitting false information, including the possibility of fine and imprisonment for knowing violations."

5. As required under § 10.1-1321.1 of the Virginia Air Pollution Control Law, applications shall not be deemed complete unless the applicant has provided a notice from the locality in which the source is located or is to be located that the site and operation of the source are consistent with all local ordinances adopted pursuant to Chapter 11 (§ 15.1-427 et seq.) of Title 15.1 of the Code of Virginia.

E. Information required.

1. Each application for a permit shall include such information as may be required by the board to determine the effect of the proposed source on the ambient air quality and to determine compliance with the emission standards which are applicable. The information required shall include, but is not limited to the following:

a. That specified on applicable permit forms furnished by the board. Any calculations shall include sufficient detail to permit assessment of the validity of such calculations. Completion of these forms serves as initial registration of new and modified sources.

b. Any additional information or documentation that

the board deems necessary to review and analyze the air pollution aspects of the source, including the submission of measured air quality data at the proposed site prior to construction, reconstruction or modification. Such measurements shall be accomplished using procedures acceptable to the board.

c. For major stationary sources, the location and registration number for all stationary sources owned or operated by the applicant (or by any entity controlling, controlled by, or *under* common control with the applicant) in the Commonwealth.

d. For major stationary sources, the analyses required by subdivision K 2 of this section shall provided b the applicant. Upon request, the board will advise an applicant of the reasonable geographic limitation on the areas to be subject to an analysis to determine the air quality impact at the proposed source.

2. The above information and analysis shall be determined and presented according to procedures and using methods acceptable to the board.

F. Standards/conditions for granting permits.

No permit will be granted pursuant to this section unless it is shown to the satisfaction of the board that the source will be designed, built and equipped to operated without causing a violation of the applicable provisions of these regulations and that the following standards and conditions have been met:

1. The source shall be designed, built and equipped to comply with standards of performance prescribed under Part V and with emission standards prescribed under Part VI.

2. The source shall be designed, built and equipped to operate without preventing or interfering with the attainment or maintenance of any applicable ambient air quality standard and without causing or exacerbating a violation of any applicable ambient air quality standard.

~~3. If the emissions of the qualifying nonattainment pollutant resulting from the source cause or contribute to emission levels which exceed the allowance permitted for such pollutant in the affected nonattainment area from new or modified sources in the applicable control strategy portion of the State Implementation Plan, then by the time the source begins operation the total allowable emissions for the qualifying nonattainment pollutants from all stationary sources (anticipated to be in operation, including the proposed source) in the affected nonattainment area must be sufficiently less than the total allowable emissions from stationary sources under these regulations prior to the application for a permit so as to not interfere with or prevent reasonable further progress.~~

3. The board determines that the following occurs:

a. By the time the source is to commence operation, sufficient offsetting emissions reductions shall have been obtained in accordance with subsection M of this section such that total allowable emissions of qualifying nonattainment pollutants from existing sources in the region, from new or modified sources which are not major emitting facilities, and from the proposed source will be sufficiently less than total emissions from existing sources, as determined in accordance with the requirements of this section, prior to the application for such permit to construct or modify so as to represent (when considered together with any applicable control measures in the State Implementation Plan) reasonable further progress; or

b. In the case of a new or modified major stationary source which is located in a zone, within the nonattainment area, identified by the administrator, in consultation with the Secretary of Housing and Urban Development, as a zone to which economic development should be targeted, that emissions of such pollutant resulting from the proposed new or modified major stationary source shall not cause or contribute to emissions levels which exceed the allowance permitted for such pollutant for such area from new or modified major stationary sources in the State Implementation Plan.

c. Any emission reductions required as a precondition of the issuance of a permit under subdivision F 3 a or F3 b of this section shall be state and federally enforceable before such permit may be issued.

4. The applicant shall demonstrate that all major stationary sources owned or operated by such applicant (or by any entity controlling, controlled by, or under common control with such applicant) in the Commonwealth *are subject to emission limitations and* are ~~either~~ in compliance, or on a ~~schedule to achieve compliance~~ *schedule for compliance* , with all applicable emission *limitations and* standards under these regulations.

5. ~~The applicable provisions of the State Implementation Plan are being carried out for the affected nonattainment area.~~ *The administrator has not determined that the applicable implementation plan is not being adequately implemented for the nonattainment area in which the proposed source is to be constructed or modified in accordance with the requirements of this section.*

6. ~~The applicant shall demonstrate, through an analysis of alternative sites, size, production processes and~~

~~environmental control techniques, that the benefits of the source significantly outweigh environmental and social costs imposed as a result of the source. This provision shall only apply to sources locating in nonattainment areas for ozone and carbon monoxide. This provision is only applicable to nonattainment areas designated in Appendix K as having a control stategy which does not demonstrate attainment of the applicable ambient air quality standard by December 31, 1982.~~ *The applicant shall demonstrate, through an analysis of alternative sites, sizes, production processes, and environmental control techniques for such proposed source, that benefits of the proposed source significantly outweigh the environmental and social costs imposed as a result of its location, construction, or modification.*

G. Action on permit application.

1. Within 30 days after receipt of an application ~~or any additional information~~ , the board shall ~~advise~~ *notify* the applicant of ~~any deficiency in such application or information~~ *the status of the application. The notification of the initial determination with regard to the status of the application shall be provided by the board in writing and shall include (i) a determination as to which provisions of Part VIII are applicable, (ii) the identification of any deficiencies, and (iii) a determination as to whether the application contains sufficient information to begin application review. The determination that the application has sufficient information to begin review is not necessarily a determination that it is complete. Within 30 days after receipt of any additional information, the board shall notify the applicant of any deficiencies in such information.* . ~~In the event that additional information is required,~~ The date of receipt of ~~the~~ *a complete* application for processing under subsection G 2 of this section shall be the date on which the board received all required information.

2. Processing time for a permit is normally 90 days following receipt of a complete application. ~~The board may extend this time period if additional information is required.~~ Processing steps normally are as follows:

a. Completion of the preliminary review and analysis in accordance with subsection ~~K~~ *J* of this section and the preliminary decision of the board.

b. ~~Public comment period and public hearing~~ *Completion of the public participation requirements in accordance with subsection H of this section* .

c. Completion of the final review and analysis and the final decision of the board.

~~3. For the public comment period and public hearing, the board shall notify the public, by advertisement in at least one newspaper of general circulation in the affected Air Quality Control Region, of the opportunity for public comment and the public hearing on the information available for public inspection under the provisions of subsection G 3 a of this section.~~

~~a. Information on the permit application (exclusive of confidential information under § 120-02-30), as well as the preliminary review and analysis and preliminary decision of the board, shall be available for public inspection during the entire public comment period in at least one location in the affected Air Quality Control Region.~~

~~b. A copy of the notice shall be sent to all local air pollution control agencies having State Implementation Plan responsibilities in the affected Air Quality Control Region, all states sharing the affected Air Quality Control Region, and to the Regional Administrator, U.S. Environmental Protection Agency.~~

~~4.~~ *3.* The board normally will take action aon all applications after completion of the review and analysis, or expiration of the public comment period (and consideration of comments therefrom) when required, unless more information is needed. The board shall notify the applicant in writing of its decision on the application, including its reasons, and shall also specify the applicable emission limitations. These emission limitations are applicable during any emission testing conducted in accordance with subsection H of this section

~~5.~~ *4.* The applicant may appeal the decision pursuant to § 120-02-09.

~~6.~~ *5.* Within five days after notification to the applicant pursuant to subsection G 4 *3* of this section, the notification and any comments received pursuant to the public comment period and public hearing shall be made available for public inspection at te same location as was the information in subsection ~~G 3 a~~ *H 6 a* of this section.

H. Public participation.

1. No later that 45 days after receiving the initial determination notification required under subdivision G 1 of this section, applicants shall notify the public about the proposed source as required in subdivision H 2 of this section. The applicant shall also provide an informational briefing about the proposed source for the public as required in subdivision H 3 of this section.

2. The public notice required under subdivision H 1 of this section shall be placed by the applicant in at least one newspaper of general circulation in the affected air quality control region. The notice shall be approved by the board and shall include, but not be limited to, the name, location, and type of the source,

and the time and place of the informational briefing.

3. The informational briefing shall be held in the locality where the source is or will be located and at least 30 days, but no later than 60 days, following the day of the publication of the public notice in the newspaper. The applicant shall inform the public about the operation and potential air quality impact of the source and answer any questions concerning air quality about the proposed source from those in attendance at the briefing. At a minimum, the applicant shall provide information on and answer questions about (i) specific pollutants and the total quantity of each which the applicant estimates will be emitted and (ii) the control technology proposed to be used at the time of the informational briefing. Representatives from the board shall attend and provide information and answer questions on the permit application review process.

4. Upon determination by the board that it will achieve the desired results in an equally effective manner, an applicant for a permit may implement an alternative plan for notifying the public as required in subdivision H 2 of this section and for providing the informational briefing as required in subdivision H 3 of this section.

5. Prior to the decision of the board, all permit applications will be subject to a public comment period of at least 30 days. In addition, at the end of the public comment period, a public hearing shall be held with notice in accordance with subdivision H 6 of this section.

6. For the public comment period and public hearing, the board shall notify the public, by advertisement in at least one newspaper of general circulation in the affected air quality control region, of the opportunity for public comment and the public hearing on the information available for public inspection under the provisions of subdivision H 6 a of this section. The notification shall be published at least 30 days prior to the day of the public hearing.

a. Information on the permit application (exclusive of confidential information under § 120-02-30), as well as the preliminary review and analysis and preliminary decision of the board, shall be available for public inspection during the entire public comment period in at least one location in the affected air quality control region.

b. A copy of the notice shall be sent to all local air pollution control agencies having State Implementation Plan responsibilities in the affected air quality control region, all states sharing the affected air quality control region, and to the regional administrator, U.S. Environmental Protection Agency.

7. If appropriate, the board may provide a public briefing on its review of the permit application prior to the public comment period but no later than the day before the beginning of the public comment period. If the board provides a public briefing, the requirements of subdivision H 6 concerning public notification shall be followed.

~~H.~~ *I.* Compliance determination and verfication by performance testing.

1. For stationary sources other than those specified in ~~subsection H~~ *subdivision I* 2 of this section, compliance with standards of performance shall a be determined in accordance with the provisions of § 120-05-02 and shall be verified by performance tests in accordance with the provisions of § 120-05-03.

2. For stationary sources of hazardous air pollutants, compliance with emission standards shall be determined in accordance with the provisions of § 120-06-02 and shall be verified by emission tests in accordance with the provisions of § 120-06-03.

3. Testing required by ~~subsections H~~ *subdivisions I* 1 and 2 of this section shall be conducted within 60 days *by the owner* after achieving the maximum production rate at which the new or modified source will be operated, but not later than 180 days after initial startup of the source; and 60 days thereafter the board shall be provided *by the owner* with two or, upon request, more copies of a written report of the results of the tests.

4. For sources subject to the provisions of Rule 5-5 or 6-1, the requirements of ~~subsections H~~ *subdivisions I* 1 through 3 of this section shall be met in all cases.

5. For sources other than those specified in ~~subsection H~~ *subdivision I* 4 of this section, the requirements of ~~subsections H~~ *subdivisions I* 1 through 3 of this section shall be met unless the board:

a. Specifies or approves, in specific cases, the use of a reference method with minor changes in methodology;

b. Approves the use of an equivalent method;

c. Approves the use of an alternative method, the results of which the board has determined to be adequate for indicating whether a specific source is in compliance;

d. Waives the requirement for testing beacause, based upon a technical evaluation of the past performance of similar source types, using similar control methods, the board reasonably expects the new or modified source to perform in compliance with applicable standards; or

e. Waives the requirement for testing because the owner of the source have demonstrated by other means to the board's satisfaction that the source is in compliance with the applicable standard.

6. The provisions for the granting of waivers under ~~subsection H~~ *subdivision I* 5 of this section are intended for use in determining the initial compliance status of a source, and the granting of a waiver does not obligate the board to do so for determining compliance once the source has been in operation for more than one year beyond the initial startup date.

~~I. Revocation of permit.~~

~~1. A permit granted pursuant to this section shall become invalid if a program of continuous construction, reconstruction or modification is not commenced within the later of the following time frames:~~

~~a. 18 months from the date the permit is granted;~~

~~b. Nine months from the date of the issuance of the last permit or other authorization (other than permits granted pursuant to this section) from any government entity.~~

~~c. Nine months from the date of the last resolution of any litigation concerning any such permits or authorizations (including permits granted pursuant to this section).~~

~~2. A permit granted pursuant to this section shall become invalid if a program of construction, reconstruction or modification is discontinued for a period of 18 months or more or if a program of construction, reconstruction or modification is not completed within a reasonable time. This provision does not apply to the period between construction of the approved phases of a phased construction project; each phase must commence construction within 18 months of the projected and approved commencement date.~~

~~3. The board may extend the periods prescribed in subsections 1 1 and 2 of this section upon satisfactory demonstration that an extension is justified. Provided there is no substantive change to the application information, the review and analysis, and the decision of the board, such extensions may be granted without being subject to the administrative requirements of this section.~~

~~J. Existence of permit no defense.~~

~~The existence of a permit under this section shall not constitute a defense to a violation of the Virginia Air Pollution Control Law or these regulations and shall not relieve any owner of the responsibility to comply with any applicable regulations, laws, ordinances and orders of the governmental entities having jurisdiction.~~

~~K.~~ *J.* Application review and analysis.

No permit shall be granted pursuant to this section unless compliance with the standards in subsection F of this section is demonstrated to the satisfaction of the board by a review and analysis of the application performed on a source-by-source basis as specified below:

1. Applications shall be subject to a control technology review to determine if such source will be designed, built and equipped to comply with all applicable standards of performance prescribed under Part V and emission standards prescribed under Part VI.

2. Applications shall be subject to an air quality analysis to determine the impact of qualifying pollutant emissions.

~~L.~~ *K.* Circumvention.

Regardless of the exemptions provided in this section, no owner or other person shall cicumvent the requirements of this section by causing or allowing a pattern of ownership or development over a geographic area of a source which, except for the pattern of ownership or development, would otherwise require a permit.

~~M.~~ *L.* Interstate pollution abatement.

1. The owner of each new or modified source, which may significantly contribute to levels of air pollution in excess of an ambient air quality standard in any quality control region outside the Commonwealth, shall provide written notice to all nearby states of the air pollution levels which may be affected by such source at least 60 days prior to the date of commencement of construction, reconstruction or modification.

2. Any state or political subdivision may petition the Administrator, EPA, for a finding that any new or modified source emits or would emit any air pollutant in amounts which will prvent attainment or maintenance of any ambient air quality standard or interfere with measures for the prevention of significant deterioration or the protection of visibility in the state implementation plan for such state. Within 60 days after receipt of suc petition and after a public hearing, the Administrator, U.S. Environmental Protection Agency, will make such a finding or deny the petition.

3. Notwithstanding any permit granted pursuant to this section, no owner or other person shall commence construction, reconstruction or modification or begin operation of a source to which a finding has been made under the provisions of ~~subsection M~~ *subdivision L* 2 of this section.

~~N.~~ *M.* Offsets.

~~The current State Implementation Plan is accommodative in nature; therefore it is not expected that the use of offsets will be needed. However, should offsets be needed the following provisions will apply:~~

1. Owners shall comply with the offset requirements of this section by obtaining emission reductions from the same source or other sources in the same nonattainment area, except that the board may allow the owner to obtain such emission reductions in another nonattainment area if (i) the other area has an equal or higher nonattainment classification than the area in which the source is located and (ii) emissions from such other area contribute to a violation of the ambient air quality standard in the nonattainment area in which the source is located. By the time a new or modified source begins operation, such emission reductions shall (i) be in effect, (ii) be state and federally enforceable and (iii) assure that the total tonnage of increased emissions of the air pollutant from the new or modified source shall be offset by an equal or greater reduction, as applicable, in the actual emissions of such air pollutant from the same or other sources in the nonattainment area.

2. The (i) ratio of total emission reductions of volatile organic compounds to total increased emissions of volatile organic compounds or (ii) the ratio of total emission reductions of nitrogen oxides to total increased emissions of nitrogen oxides in nonattainment areas designated in Appendix K shall be at least the following:

a. Ozone nonattainment areas classified as marginal - 1.1 to one.

b. Ozone nonattainment areas classified as moderate - 1.15 to one.

c. Ozone nonattainment areas classified as serious - 1.2 to one.

d. Ozone nonattainment areas classified as severe - 1.3 to one.

3. Emission reductions otherwise required by these regulations shall not be creditable as emissions reductions for purposes of any such offset requirement. Incidental emission reductions which are not otherwise required by these regulations shall be creditable as emission reductions for such purposes if such emission reductions meet the requirements of subdivision M 1 of this section.

4. The board shall allow an owner to offset by alternative or innovative means emission increases from rocket engine and motor firing, and cleaning related to such firing, at an existing or modified major source that tests rocket engines or motors under the following conditions:

a. Any modification proposed is solely for the purpose of expanding the testing of rocket engines or motors at an existing source that is permitted to test such engines on November 15, 1990.

b. The source demonstrates to the satisfaction of the board that it has used all reasonable means to obtain and utilize offsets, as determined on an annual basis, for the emissions increases beyond allowable levels, that all available offsets are being used, and that sufficient offsets are not available to the source.

c. The source has obtained a written finding from the U.S. Department of Defense, U.S. Department of Transportation, National Aeronautics and Space Administration or other appropriate federal agency, that the testing of rocket motors or engines at the facility is required for a program essential to the national security.

d. The owner will comply with an alternative measure, imposed by the board, designed to offset any emission increases beyond permitted levels not directly offset by the source. In lieu of imposing any alternative offset measures, the board may impose an emissions fee to be paid to the board which shall be an amount no greater than 1.5 times the average cost of stationary source control measures adopted in that nonattainment area during the previous three years. The board shall utilize the fees in a manner that maximizes the emissions reductions in that nonattainment area.

~~1.~~ *5.* For sources subject to the provisions of this section, the baseline for determining credit for emissions reduction is the emissions limit under the applicable State Implementation Plan in the effect at the time the application to construct is filed, except that the offset baseline shall be the actual emissions of the source from which offset credit is obtained where:

a. The demonstration of reasonable further progress and attainment of ambient air quality standards is based upon the actual emission of sources located within a designated nonattainment area; or

b. The applicable State Implementation Plan does not contain an emissions limitation for that source or source category.

~~2.~~ *6.* Where the emissions limit under the applicable State Implementation Plan allows greater emissions than the potential to emit of the source, emissions offset credit will be allowed only for control below this potential.

~~3.~~ *7.* For an existing fuel combustion source, credit shall be based on the allowable ~~emission~~ *emissions* under the applicable State Implementation Plan for

the type of fuel being burned at the time the application to construct if filed. If the *owner of the* existing source commits to switch to a cleaner fuel at some future date, emissions offset credit based on the allowable (or actual) emissions for the fuels involved is not acceptable, unless the permit is conditioned to require the use of a specified alternative control measure which would achieve the same degree of emissions reduction should the source switch back to a dirtier fuel at some later date. The board will ensure that adequate long-term supplies of the new fuel are available before granting emissions offset credit for fuel switches.

~~4. Emissions reductions achieved by shutting down an existing source or permanently curtailing production or operating hours below baseline levels may be credited, provided that the work force to be affected has been notified of the proposed shutdown or curtailment. Source shutdowns and curtailments in production or operating hours occurring prior to the date the new source application is filed generally may not be used for emissions offset credit. However, where an applicant can establish that it shut down or curtailed production after August 7, 1977, or less than one year prior to the date of permit application, whichever is earlier, and the proposed new source is a replacement for the shutdown or curtailment credit for sue shutdown or curtailment may be applied to offset emissions from the new source.~~

8. Emissions reductions achieved by shutting down an existing source or curtailing production or operating hours below baseline levels may be generally credited if such reductions are permanent, quantifiable, and federally and state enforceable. In addition, the shutdown or curtailment is creditable only if it occured on or after January 1, 1991.

~~5.~~ *9.* No emissions credit may be allowed for replacing one hydrocarbon compound with another of lesser reactivity, except for those compounds listed in Table 1 of EPA's "Recommended Policy on Control of Volatile Organic Compounds" (42 FR 35314, July 8, 1977).

~~6. All emission reductions claimed as offset credit shall be federally and state enforceable.~~

~~7.~~ *10.* ~~Procedures relating to the permissible location of offsetting emissions shall be followed which are at least as stringent as those set out in Section IV.D of~~ *The provisions of* Appendix S to 40 CFR Part 15 *shall be followed to the extent that they do not conflict with this subsection .*

~~8.~~ *11.* Credit for an emissions reduction can be claimed to the extent that the bord has not relied on it in issuing any permit under Part VIII or has not relied on it in demonstrating attainment or reasonable further progress.

N. De minimis increases and stationary source modification alternatives for ozone nonattainment areas classified as serious or severe in Appendix K.

1. De minimis increases. Increased emissions of volatile organic compounds or nitrogen oxides resulting from any physical change in, or change in the method of operation of, a major stationary source located in an ozone nonattainment area classified as serious or severe in Appendix K shall be considered de minimis for purposes of determining the applicability of the permit requirements under this section if the increase in net emissions of the same pollutant from such source is 25 tons or less when aggregated with all other net increases in emissions from the source over any period of five consecutive calendar years which includes the calendar year in which such increase occurred.

2. Modifications of major stationary sources emitting less than 100 tons per year of volatile organic compounds or nitrogen oxides.

a. Any physical change in, or change in the method of operation of, a major stationary source with a potential to emit of less than 100 tons per year of volatile organic compounds or nitrogen oxides which results in an increase in emissions of the same pollutant from any discrete operation, unit, or other pollutant emitting activity at the source that is not de minimis under subdivision N 1 of this section shall be considered a major modification under this section. However, in applying emission standards under Part V of these regulations to the source, the requirement to apply best available control technology shall be substituted for the requirement to comply with the lowest achievable emission rate.

b. If the owner elects to offset the increase of volatile organic compounds or of nitrogen oxides by a greater reduction in emissions of the pollutant being increased from other operations, units, or activities within the source at an internal offset ratio of at least 1.3 to 1, such increase shall not be considered a major modification under this section.

3. Modifications of volatile organic compounds or nitrogen oxides.

a. Any physical change in, or change in the method of operation of, a major stationary source with a potential to emit of 100 tons per year or more of volatile organic compounds or nitrogen oxides which results in an increase in emissions of the same pollutant from any discrete operation, unit, or other pollutant emitting activity at that source that is not de minimis under subdivision N 1 of this section shall be considered a major modification under this section.

b. In applying emission standards under Part V of these regulations to the source, the requirement to apply best available control technology shall be substituted for the requirement to comply with the lowest achievable emission rate, if the owner elects to offset the increase by a greater reduction in emissions of the pollutant being increased from other operations, units, or activities within the source at an internal offset ratio of at least 1.3 to 1.

O. Exception.

The provisions of this section do not apply to a source or modification that would be a major stationary source or major modification only if fugitive emissions, to the extent quantifiable, are considered in claculating the potential to emit of the source or modification and the source does not belong to any of the following categories:

1. Coal cleaning plants (with thermal dryers).

2. Kraft pulp mills.

3. Portland cement plants.

4. Primary zinc smelters.

5. Iron and steel mills.

6. Primary aluminum ore reduction plants.

7. Primary copper smelters.

8. Municipal incinerators capable of charging more than 250 tons refuse per day.

9. Hydrofluoric acid plants.

10. Sulfuric acid plants.

11. Nitric acid plants.

12. Petroleum refineries.

13. Lime plants.

14. Phosphate rock processing plants.

15. Coke oven batteries.

16. Sulfur recovery plants.

17. Carbon black plants (furnace process).

18. Primary lead smelters.

19. Fuel conversion plants.

20. Sintering plants.

21. Secondary metal production plants.

22. Chemical process plants.

23. Fossil-fuel boilers (or combination thereof) totaling more than 250 million British thermal units per hour heat input.

24. Petroleum storage and transfer units with a total storage capacity exceeding 300,000 barrels.

25. Taconite ore processing plants.

26. Glass fiber processing plants.

27. Charcoal production plants.

28. Fossil fuel-fired steam electric plants of more than 250 million British thermal units per hour heat input.

29. Any other stationary source category which, as of August 7, 1980, is being regulated under Section 111 or 112 of the federal Clean Air Act.

P. Compliance with local zoning requirements.

The owner shall comply in all respects with any existing zoning ordinances and regulations in the locality in which the source is located or proposes to be located; provided, however, that such compliance does not relieve the board of its duty under § 120-02-14 of these regulations and § 10.1-1307 E of the Virginia Air Pollution Control Law to independently consider relevant facts and circumstances.

Q. Reactivation and permanent shutdown.

1. The reactivation of a stationary source is not subject to provisions of this section unless a decision concerning shutdown has been made pursuant to the provisions of subdivisions Q 2 through 4 of this section or subdivision P 5 of § 120-03-04.

2. Upon a final decision by the board that a stationary source is shut down permanently, the board shall revoke the permit by written notification to the owner and remove the source from the emission inventory or consider its emissions to be zero in any air quality analysis conducted; and the source shall not commence operation without a permit being issued under the applicable provisions of Part VIII.

3. The final decision shall be rendered as follows:

a. Upon a determination that the source has not operated for a year or more, the board shall provide written notification to the owner (i) of its tentative decision that the source is considered to be shut down permanently; (ii) that the decision shall become final if the owner fails to provide, within three months of the notice, written response

to the board that the shutdown is not to be considered permanent; and (iii) that the owner has a right to a formal hearing on this issue before the board makes a final decision. The response from the owner shall include the basis for the assertion that the shutdown is not to be considered permanent and a projected date for restart-up of the source and shall include a request for a formal hearing if the owner wishes to exercise that right.

b. If the board should find that the basis for the assertion is not sound or the projected restart-up date allows for an unreasonably long period of inoperation, the board shall hold a formal hearing on the issue if one is requested or, if no hearing is requested, the decision to consider the shutdown permanent shall become final.

4. Nothing in these regulations shall be construed to prevent the board and the owner from making a mutual determination that a source is shutdown permanently prior to any final decision rendered under subdivision Q 3 of this section.

R. Transfer of permits.

1. No person shall transfer a permit from one location to another, or from one piece of equipment to another.

2. In the case of a transfer of ownership of a stationary source, the new owner shall abide by any current permit issued to the previous owner. The new owner shall notify the board of the change in ownership within 30 days of the transfer.

3. In the case of a name change of a stationary source, the owner shall abide by any current permit issued under the previous source name. The owner shall notify the board of the change in source name within 30 days of the name change.

S. Permit invalidation, revocation, and enforcement.

1. A permit granted pursuant to this section shall become invalid if a program of continuous construction, reconstruction or modification is not commenced within the latest of the following time frames:

a. Eighteen months from the date the permit is granted.

b. Nine months from the date of the issuance of the last permit or other authorization (other than permits granted pursuant to this section) from any government entity.

c. Nine moths from the date of the last resolution of any litigation concerning any such permits or authorizations (including permits granted pursuant to this section).

2. A permit granted pursuant to this section shall become invalid if a program of construction, reconstruction or modification is discontinued for a period of 18 months or more or if a program of construction, reconstruction or modification is not completed within a reasonable time. This provision does not apply to the period between construction of the approved phases of a phased construction project; each phase must commence construction within 18 months of the projected and approved commencement date.

3. The board may extend the periods prescribed in subdivisions S 1 and 2 of this section upon satisfactory demonstration that an extension is justified. Provided there is no substantive change to the application information, the review and analysis, and the decision of the board, such extensions may be granted without being subject to the administrative requirements of this section.

4. Any owner who constructs or operates a source or modification not in accordance (i) with the application submitted pursuant to this section or (ii) with the terms and conditions of any approval to construct or operate, or any owner of a source or modification subject to this section who commences construction or operation without applying for and receiving approval hereunder, shall be subject to appropriate enforcement action.

5. Permits issued under this section shall be subject to such terms and conditions set forth in the permit as the board may deem necessary to ensure compliance with all requirements of the regulations.

6. The board may revoke any permit if the permittee:

a. Knowingly makes material misstatements in the permit application or any amendments thereto;

b. Fails to comply with the terms or conditions of the permit;

c. Fails to comply with any emission standards applicable to an emissions unit included in the permit;

d. Causes emissions from the stationary source which result in violations of, or interfere with the attainment and maintenance of, any ambient air quality standard; or fails to operate in conformance with any applicable control strategy, including any emission standards or emission limitations, in the State Implementation Plan in effect at the time that an application is submitted; or

e. Fails to comply with the applicable provisions of this section.

7. The board may suspend, under such conditions and for such period of time as the board may prescribe, any permit for any of the grounds for revocation contained in subdivision S 6 of this section or for any other violations of these regulations.

8. Violation of these regulations shall be grounds for revocation of permits issued under this section and are subject to the civil charges, penalties and all other relief contained in Part II of these regulation and the Virginia Air Pollution Control Law.

9. The board shall notify the applicant in writing of its decision, with its reasons, to change, suspend or revoke a permit or to render a permit invalid.

T. Existence of permit no defense.

The existence of a permit under this section shall not constitute a defense to a violation of the Virginia Air Pollution Control Law or these regulations and shall not relieve any owner of the responsibility to comply with any applicable regulations, laws, ordinances and orders of the governmental entities having jurisdiction.

APPENDIX K.
NONATTAINMENT AREAS.

Nonattainment Areas are geographically defined below by locality for the criteria pollutants indicated. Following the name of each nonattainment area, in parentheses, is the classification assigned pursuant to Section 181 (a) for ozone and Section 186 (a) for carbon monoxide of the Federal Clean Air Act.

A. Ozone.

1. Northern Virginia Ozone Nonattainment Area (serious).

Arlington County	Alexandria City
Fairfax County	Fairfax City
Loudoun County	Falls Church City
Prince William County	Manassas City
Stafford County	Manassas Park City

2. Richmond Ozone Nonattainment Area (moderate).

Charles City County	Colonial Heights City
Chesterfield County	Hopewell City
Hanover County	Richmond City
Henrico County	

3. Hampton Roads Ozone Nonattainment Area (marginal).

James City County	Poquoson City
York County	Portsmouth City
Chesapeake City	Suffolk City
Hampton City	Virginia Beach City
Newport News City	Williamsburg City
Norfolk City	

4. White Top Mountain Ozone Nonattainment Area (marginal - rural transport area). The portion above 4,500 feet elevation in Smyth County (located within the Jefferson National forest).

B. Carbon monoxide.

Northern Virginia Carbon Monoxide Nonattainment Area (moderate).

Arlington County	Alexandria City

APPENDIX P.
VOLATILE ORGANIC COMPOUND *AND NITROGEN OXIDES* EMISSIONS CONTROL AREAS.

~~Volatile Organic Compound Emissions Control Areas~~ are ~~geographically defined as follows:~~

~~Air Quality Control Region 1 None~~

~~Air Quality Control Region 2 None~~

~~Air Quality Control Region 3 None~~

~~Air Quality Control Region 4~~
~~Stafford County~~

~~Air Quality Control Region 5~~
~~Richmond City~~
~~Chesterfield County~~
~~Henrico County~~

~~Air Quality Control Region 6~~
~~Chesapeake City~~
~~Hampton City~~
~~Newport News City~~
~~Norfolk City~~
~~Portsmouth City~~
~~Suffolk City~~
~~Virginia Beach City~~

~~Air Quality Control Region 7~~
~~Alexandria City~~
~~Fairfax City~~
~~Falls Church City~~
~~Manassas City~~
~~Manassas Park City~~
~~Arlington County~~
~~Fairfax County~~
~~Loudoun County~~
~~Prince William County~~

Emissions Control Areas are geographically defined below by locality for the pollutants indicated.

A. Volatile Organic Compounds

1. Northern Virginia Emissions Control Area

Arlington County	Alexandria City
Fairfax County	Fairfax City
Loudoun County	Falls Church City
Prince William County	Manassas City
Stafford County	Manassas Park City

2. Richmond Emissions Control Area

Charles City County	Colonial Heights City
Chesterfield County	Hopewell City
Hanover County	Richmond City
Henrico County	

3. Hampton Roads Emissions Control Area

Chesapeake City	Portsmouth City
Hampton City	Suffolk City
Newport News City	Virginia Beach City
Norfolk City	

B. Nitrogen Oxides

1. Northern Virginia Emissions Control Area

Arlington County	Alexandria City
Fairfax County	Fairfax City
Loudoun County	Falls Church City
Prince William County	Manassas City
Stafford County	Manassas Park City

2. Richmond Emissions Control Area

Charles City County	Colonial Heights City
Chesterfield County	Hopewell City
Hanover County	Richmond City
Henrico County	

3. Hampton Roads Emissions Control Area

Chesapeake City	Portsmouth City
Hampton City	Suffolk City
Newport News City	Virginia Beach City
Norfolk City	

APPENDIX R.
STATIONARY SOURCE PERMIT EXEMPTION LEVELS.

I. ~~Determination of exemption levels~~ *General* .

A. In determining whether a facility is exempt from the requirements of § 120-08-01, the provisions of Sections II through VIII of this appendix are independent from the provisions of Section IX of this appendix. A facility must be determined to be exempt both under the provisions of Sections II through VIII taken as a group and under the provisions of Section IX to be exempt from § 120-08-01.

B. In determining whether a facility is exempt from the requirements of § 120-08-01 under the provisions of Sections II and III of this appendix, the definitions in the rule in Part IV that would cover the facility if it were an existing source shall be used unless deemed inappropriate by the board.

II. New source exemption levels by size.

Facilities as specified below shall be exempt from the requirements of § 120-08-01 as they pertain to construction, reconstruction or relocation.

A. Fuel burning equipment.

1. Any unit using solid fuel with a maximum heat input of less than ~~350,000~~ *1,000,000* Btu per hour.

2. Any unit using liquid fuel with a maximum heat input of less than 10,000,000 Btu per hour.

3. Any unit using liquid and gaseous fuel with a maximum heat input of less than 10,000,000 Btu per hour.

4. Any unit using gaseous fuel with a maximum heat input of less than 50,000,000 Btu per hour , *unless subject to a new source performance standard in Rule 5-5* .

5. Any unit that powers a mobile source but is removed for maintenance or repair and testing.

B. Solvent metal cleaning operations.

Any solvent metal cleaning operation with an uncontrolled emission rate of not more than 7 tons per year, 40 pounds per day and 8 pounds per hour.

C. Volatile organic compound storage and transfer operations.

Any storage or transfer operation involving petroleum liquids and other volatile organic compounds with a vapor pressure less than 1.5 pounds per square inch absolute under actual storage conditions or, in the case of loading or processing, under actual loading or processing conditions; and any operation specified below:

1. Volatile organic compound transfer operations.

a. Any tank of 2,000 gallons or less storage capacity.

b. Any operation outside the volatile organic compound emissions control areas designated in Appendix P.

2. Volatile organic compound storage operations. Any tank of 40,000 gallons or less storage capacity.

D. Large appliance coating application systems.

Any coating application system if it is within a plant that has an uncontrolled emission rate of not more than 7 tons per year, 40 pounds per day and 8 pounds per hour.

E. Magnet wire coating application systems.

Any coating application system if it is within a plant that has an uncontrolled emission rate of not more than 7 tons per year, 40 pounds per day and 8 pounds per hour.

F. Automobile and light duty truck coating application systems.

1. Any coating application system if it is within a plant that has an uncontrolled emission rate of not more than 7 tons per year, 40 pounds per day and 8 pounds per hour.

2. Any vehicle refinishing operation.

G. Can coating application systems.

Any coating application system if it is within a plant that has an uncontrolled emission rate of not more than 7 tons per year, 40 pounds per day and 8 pounds per hour.

H. Metal coil coating application systems.

Any coating application system if it is within a plant that has an uncontrolled emission rate of not more than 7 tons per year, 40 pounds per day and 8 pounds per hour.

I. Paper and fabric coating application system.

Any coating application system if it is within a plant that has an uncontrolled emission rate of not more than 7 tons per year, 40 pounds per day and 8 pounds per hour.

J. Vinyl coating application systems.

Any coating application system if it is within a plant that has an uncontrolled emission rate of not more than 7 tons per year, 40 pounds per day and 8 pounds per hour.

K. Metal furniture coating application systems.

Any coating application system if it is within a plant that has an uncontrolled emission rate of not more than 7 tons per year, 40 pounds per day and 8 pounds per hour.

L. Miscellaneous metal parts and products coating application systems.

1. Any coating application system if it is within a plant that has an uncontrolled emission rate of not more than 7 tons per year, 40 pounds per day and 8 pounds per hour.

2. Any vehicle customizing coating operation, if production is less than 20 vehicles per day.

3. Any vehicle refinishing operation.

4. Any fully assembled aircraft or marine vessel exterior coating operation.

M. Flatwood paneling coating application systems.

Any coating application system if it is within in a plant that has an uncontrolled emission rate of not more than 7 tons per year, 40 pounds per day and 8 pounds per hour.

N. Graphic arts (printing processes).

Any printing process if it is within a plant that has an uncontrolled emission rate of not more than 7 tons per year, 40 pounds per day and 8 pounds per hour.

O. Petroleum liquid storage and transfer operations.

Any storage or transfer operation involving petroleum liquids with a vapor pressure less than 1.5 pounds per square inch absolute under actual storage conditions or, in the case of loading or processing, under actual loading or processing conditions (kerosene and fuel oil used for household heating have vapor pressures of less than 1.5 pounds per square inch absolute under actual storage conditions; therefore, kerosene and fuel oil are not subject to the provisions of § 120-08-01 when used or stored at ambient temperatures); and any operation specified below:

1. Bulk terminals - gasoline bulk loading operations. Any operation outside volatile organic compound emissions control areas designated in Appendix P.

2. Gasoline dispensing facilities. Any gasoline dispensing facility.

3. Bulk plants - gasoline bulk loading operations.

a. Any facility with an expected daily throughput of less than 4,000 gallons.

b. Any operation outside volatile organic compound emissions control areas designated in Appendix P.

4. Account/tank trucks. No permit is required for account/tank trucks, but permits issued for gasoline storage/transfer facilities should include a provision that all associated account/tank trucks meet the same requirements as those trucks serving existing facilities.

5. Petroleum liquid storage operations.

a. Any tank of 40,000 gallons or less storage capacity.

b. Any tank of less than 420,000 gallons storage capacity for crude oil or condensate stored, processed or treated at a drilling and production facility prior to custody transfer.

c. Any tank storing waxy, heavy pour crude oil.

P. ~~Drying~~ *Dry* cleaning ~~systems~~ *plants* .

Any ~~petroleum~~ dry cleaning ~~system~~ *plant* with a total manufacturers' rated solvent dryer capacity less than 84 pounds as determined by the applicable new source performance standard in § 120-05-0502.

Q. Wood product manufacturing plants.

Any addition of, relocation of or change to a woodworking machine within a plant provided the system air movement capacity, expressed as the cubic feet per minute of air, and maximum control efficiency of the control system are not decreased.

R. Wood sawmills.

Any wood sawmill.

III. New sources with no exemptions.

Facilities as specified below shall not be exempt, regardless of size or emission rate, from the requirements of § 120-08-01 as they pertain to construction, reconstruction or relocation.

A. Petroleum ~~refinery~~ ~~operations~~ *refineries* .

B. Asphalt plants.

C. Chemical fertilizer manufacturing ~~operations~~ *plants* .

D. Kraft pulp mills.

E. Sand and gravel processing ~~operations~~ *facilities* .

F. Coal preparation plants.

G. Stone quarrying and processing ~~operations~~ *facilities* .

H. Portland cement plants.

I. Wood product manufacturing ~~operations~~ *plants* .

J. Secondary metal operations.

K. Lightweight aggregate process operations.

L. Feed manufacturing ~~operations~~ *plants* .

M. Incinerators.

N. Coke ovens.

O. Sulfuric acid production units.

P. Sulfur recovery operations.

Q. Primary metal operations.

R. Nitric acid production units.

S. Concrete batching plants.

T. Pharmaceutical products manufacturing ~~operations~~ *plants* .

U. Rubber tire manufacturing ~~operations~~ *plants* .

IV. New source exemption levels by emission rate.

Facilities not covered by Section II or III of this appendix ~~shall be exempt as specified below.~~

~~A.~~ ~~Facilities~~ with uncontrolled emission rates less than all of the significant emission rates specified below shall be exempt from the requirements of § 120-08-01 pertaining to construction, reconstruction or relocation.

~~SIGNIFICANT~~ EMISSION RATES

Carbon monoxide - 100 tons per year.

Nitrogen dioxide - ~~10~~ *40* tons per year.

Sulfur dioxide - ~~10~~ *40* tons per year.

Particulate matter *(PM10)* - ~~1 ton~~ *15 tons* per year.

Volatile organic compounds - ~~7~~ *25* tons per year.

Lead - 0.6 ton per year.

~~B. Where a source is constructed in increments which individually are not subject to approval under this section and which are not part of a program of construction in planned incremental phases approved by the board, all such increments shall be added together for determining the applicability of this section.~~

V. Modified source exemption levels by emission rate.

~~A.~~ Facilities with increases in uncontrolled emission rates less than all of the ~~significant~~ emission rates specified below shall be exempt from the requirements of § 120-08-01 pertaining to modification.

~~SIGNIFICANT~~ EMISSION RATES

Carbon monoxide - 100 tons per year.

Nitrogen dioxide - 10 tons per year.

Sulfur dioxide - 10 tons per year.

Particulate matter *(PM10)* - ~~1 ton~~ *10 tons* per year.

Volatile organic compounds - ~~7~~ *10* tons per year.

Lead - 0.6 ton per year.

~~B. Where a source is modified in increments which individually are not subject to approval under this section and which are not part of a program of modification in planned incremental phases approved by the board, all such increments shall be added together for determining the applicability of this section.~~

VI. New source performance standards and national emission standards for hazardous air pollutants.

Regardless of the provisions of Sections II, IV and V of this appendix, affected facilities subject to Rule 5-5 or subject to Rule 6-1 shall not be exempt from the provisions of § 120-08-01 , *with the exception of those facilities which would be subject only to recordkeeping or reporting requirements or both under Rule 5-5 or Rule 6-1*

VII. Relocation of portable facilities.

Regardless of the provisions of Sections II, III, IV, V and VI of this appendix, a permit will not be required for the relocation of a portable emissions unit for which a permit has been previously granted under Part VIII provided that:

1. The emissions of the unit at the new location would be temporary;

2. The emissions from the unit would not exceed its allowable emissions;

3. The unit would not undergo modification or reconstruction;

4. The unit is suitable to the area in which it is to be located; and

5. Reasonable notice is given to the board prior to the relocation identifying the proposed new location and the probable duration of operation at the new location. Such notice shall be given to the board not less than 15 days in advance of the proposed relocation unless a different time duration is previously approved by the board.

VIII. Requirements for exempted facilities.

~~In determining whether a facility is exempt from the provisions of § 120-08-01 under the provisions of Sections II and III of this appendix, the applicability provisions in the rules in Part IV that would cover the facility if it were an existing source shall be used unless deemed inappropriate by the board. A new or modified source which would be exempt from the provisions of Part IV if it were an existing source shall also be exempt from the provisions of § 120-08-01. At no time shall a new or modified source be exempt from the provisions of § 120-08-01 if it meets the applicability criteria in this appendix. A new or modified source which is exempt from the provisions of § 120-08-01 based on the criteria in this appendix but which exceeds the applicability thresholds in Part IV if it were an existing source shall be subject to the provisions of Part IV.~~ *Any facility exempted from the provisions of § 120-08-01 by Section II of this appendix shall be subject to the provisions of any rule which would apply to the facility if it were an existing source unless specifically exempted by that rule.*

IX. Exemption levels for toxic pollutants.

A. Facilities with ~~a potential to emit~~ *an increase in the uncontrolled emission rate of* a toxic pollutant equal to or less than the exempt emission rate calculated using the ~~following~~ exemption formulas for the applicable TLV ® *in subsection D of this section* shall be exempt from the requirements of § 120-08-01 pertaining to ~~construction,~~ modification, ~~reconstruction or relocation~~ *provided the increase in the uncontrolled emission rate of the pollutant does not exceed 22.8 pounds per hour or 100 tons per year .*

B. Facilities with an uncontrolled emission rate of a toxic pollutant equal to or less than the exempt emission rate calculated using the exemption formulas for the applicable TLV ® in subsection D of this section shall be exempt from the requirements of § 120-08-01 pertaining to construction, reconstruction or relocation, provided the uncontrolled emission rate of the pollutant does not exceed 22.8 pounds per hour or 100 tons per year.

C. If more than one exemption formula applies to a toxic pollutant emitted by a ~~source~~ *facility* , the ~~potential to emit~~ *uncontrolled emission rate of* that pollutant shall be equal to or less than both applicable exemption formulas in order for the source to be exempt for that pollutant. The exemption formulas apply on an individual basis to each toxic pollutant for which a TLV ® has been established.

D. Exemption formulas.

~~A.~~ *1.* For toxic pollutants with a TLV-C ® , the following exemption formula applies ~~; provided the potential to emit does not exceed 22.8 pounds per hour~~ :

Exempt Emission Rate (pounds per hour) =

TLV-C (mg/m³) x 0.033

~~B.~~ *2.* For toxic pollutants with both a TLV-STEL ® and a TLV-TWA ® , the following exemption formulas apply ~~; provided the potential to emit does not exceed 22.8 pounds per hour or 100 tons per year~~ :

Exempt Emission Rate (pounds per hour) =

TLV-STEL ® (mg/m³) x 0.033

Exempt Emission Rate (tons per year) =

TLV-TWA ® (mg/m³) x 0.145

~~C.~~ *3.* For toxic pollutants with only a TLV-TWA ® , the following exemption formulas apply ~~; provided the potential to emit does not exceed 22.8 pounds per hour or 100 tons per year~~ :

Exempt Emission Rate (pounds per hour) =

TLV-TWA ® (mg/m³) x 0.066

Exempt Emission Rate (tons per year) =

TLV-TWA ® (mg/m³) x 0.145

~~D.~~ *E.* Exemption from the ~~provisions of this rule~~ *requirements of § 120-08-01* for any ~~stationary source or operation not part of a stationary source~~ *facility* which has ~~a potential to emit~~ *an uncontrolled emission rate of* any toxic pollutant without a TLV ® shall be determined by the board using available health effects information.

~~E.~~ *F.* The exemption determination shall be made by the board using information submitted by the owner at the request of the board as set out in § 120-05-0305.

G. Facilities as specified below shall not be exempt, regardless of size or emission rate, from the requirements of § 120-08-01 as they pertain to modification, construction, reconstruction or relocation.

1. Incinerators, unless the incinerator is used exclusively as air pollution control equipment.

2. Ethylene oxide sterilizers.

3. Boilers or industrial furnaces burning hazardous waste fuel for energy recovery or distruction, or processing for materials recovery or as an ingredient. For the purposes of this section, hazardous waste fuel means (i) hazardous waste that is burned for energy recovery or (ii) fuel produced from hazardous waste by processing, blending or other treatment (see § 1 of the Hazardous Waste Management Regulations, VR 672-10-1). Hazardous waste means a solid waste or combination of solid waste which, because of its quantity, concentration or physical, chemical or infectious characteristics, may (i) cause or significantly contribute to an increase in mortality or an increase in serious irreversible or incapacitating illness, or (ii) pose a substantial present or potential hazard to human health or the environment when improperly treated, stored, transported, disposed of, or otherwise managed (§ 10.1-1400 of the Virginia Waste Management Act). This subsection shall not apply to boilers or industrial furnaces burning used oil, which is defined as any oil that has been refined from crude oil, used, and as a result of such use, is contaminated by physical or chemical impurities (§ 1 of the Hazardous Waste Management Regulations, VR 672-10-1).

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF AIR POLLUTION CONTROL

DOCUMENT CERTIFICATION FORM

INSTRUCTIONS FOR USE

Various provisions of the Regulations for the Control and Abatement of Air Pollution require that certain documents submitted to the Board or the Department be signed by a responsible official with certification that the information contained in the statement is accurate to the best knowledge of the individual certifying the statement. Documents covered by this requirement include, but are not limited to, permit applications, registrations, emission statements, emission testing and monitoring reports, or compliance certifications. The certification should include the full name, title, signature, date of signature, and telephone number of the responsible official. A responsible official is defined as follows:

1. For a corporation, association or cooperative, a responsible official is either (i) the president, secretary, treasurer, or a vice-president of the corporation in charge of a principal business function, or any other person who performs similar policy or decision-making functions for the corporation, or (ii) a duly authorized representative of such cooperation if the representative is responsible for the overall operation of one or more manufacturing, production, or operating facilities applying for or subject to a permit and either (i) the facilities employ more than 250 persons or have gross annual sales or expenditures exceeding $25 million (in second quarter 1980 dollars), or (ii) the authority to sign documents has been assigned or delegated to such representative in accordance with corporate procedures.

2. For a partnership or sole proprietorship, a responsible official is a general partner or the proprietor, respectively.

3. For a municipality, state, federal, or other public agency, a responsible official is either a principal executive officer or ranking elected official. A principal executive officer of a federal agency includes the chief executive officer having responsibility for the overall operations of a principal geographic unit of the agency.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF AIR POLLUTION CONTROL

DOCUMENT CERTIFICATION FORM

(see other side for instructions)

I certify under penalty of law that this document and all attachments were prepared under my direction or supervision in accordance with a system designed to assure that qualified personnel properly gather and evaluate the information submitted. Based on my inquiry of the person or persons who manage the system, or those persons directly responsible for gathering and evaluating the information, the information submitted is, to the best of my knowledge and belief, true, accurate, and complete. I am aware that there are significant penalties for submitting false information, including the possibility of fine and imprisonment for knowing violations.

SIGNATURE: _____ DATE: _____

NAME: _____

TITLE: _____

COMPANY: _____

PHONE: _____

DEPARTMENT OF TRANSPORTATION (COMMONWEALTH TRANSPORTATION BOARD)

REGISTRAR'S NOTICE: Due to its length, the Hazardous Materials Transportation Rules and Regulations at Bridge-Tunnel Facilities filed by the Commonwealth Transportation Board are not being published in full text. However, those portions of the regulation being amended are set out in full text. In accordance with § 9-6.14:22 of the Code of Virginia a summary in lieu of full text is being published. The full text of the regulation is available for inspection at the offices of the Registrar of Regulations and the Department of Transportation.

Title of Regulation: **VR 385-01-5. Hazardous Materials Transportation Rules and Regulations at Bridge-Tunnel Facilities.**

Statutory Authority: §§ 33.1-12 and 33.1-49 of the Code of Virginia.

Public Hearing Date: August 10, 1992 - 1 p.m.
(See Calendar of Events section for additional information)

Summary:

The Virginia Department of Transportation, in conjunction with Virginia Polytechnic Institute and State University, has developed a handbook entitled "Hazardous Materials Transportation Rules and Regulations at Bridge-Tunnel Facilities."

The purpose of this manual is to provide the current rules and regulations, including operating requirements, for the transport of hazardous materials through Virginia's Bridge-Tunnel facilities. The manual and its contents are consistent with the Commonwealth of Virginia's regulations and in conformance with Department of Transportation regulations as identified in the Code of Federal Regulations (Title 49).

Further, the manual provides interested parties with detailed and specific information concerning the regulations established by the Virginia Department of Transportation and the Chesapeake Bay Bridge-Tunnel District governing the transportation of hazardous materials, as well as a useful table (alphabetized) of hazardous materials transported through the Commonwealth, and the restrictions governing their transport.

The amendments to the manual:

1. Change the regulations to allow vehicles which use natural gas (or gases with similar properties) as fuel to use the tunnel facilities in the Commonwealth; and

2. Change the regulations pertaining to the conditions under which low-pressure liquid oxygen can be transported through tunnel facilities in the Commonwealth.

The proposed amendments appear in Appendix 2, "Compressed Gases," and in the "Hazardous Materials Table." (See amendments below.)

VR 385-01-5. Hazardous Materials Transportation Rules and Regulations at Bridge-Tunnel Facilities.

2. Compressed gases.

(a.1) No vehicle shall enter the facilities if its load includes a compressed gas which is listed in section 14 and referenced to this subsection, unless such compressed gas is in a tube or cylinder of two inches or less in outside diameter and four fluid ounces or less in capacity. 2) Empty containers which last contained such a compressed gas are not allowed passage when the quantity and/or container size limitations exceed those described above. 3) No empty tank vehicle is allowed passage if it is used in the transportation of any compressed gas referenced to this subsection.

(b.1) Compressed gases listed in section 14 and referenced to this subsection are restricted to a maximum quantity per vehicle of 100 pounds gross weight providing the gross weight of each tube or cylinder is 10 pounds or less, and except that cyclopropane or ethylene for hospital use is restricted to a maximum quantity per vehicle of 20 tubes or cylinders measuring 20 inches or less in length, and 4 1/2 inches or less in outside diameter. Acetylene, liquefied petroleum gas *(LPG), compressed natural gas (CNG),* or other gases having similar chemical properties will be allowed passage providing that the load per vehicle is limited to one cylinder not exceeding 323 cubic feet in capacity, 42 inches long, 12 and 7/8 inches in outside diameter; and 244 pounds gross weight (60 pound cylinder) ; ~~but the tank~~ . *Low pressure liquid oxygen (under 40 PSIG) is allowed passage providing that the load per vehicle is limited to one cylinder not exceeding 70 gallons in liquid capacity. The container* valve must be enclosed by a protective metal safety cap properly and securely fitted in place. The inspection by authorized facility personnel reveals that LP gas containers are properly valved-off, securely attached, and determined to be safe for travel. The valves must remain closed until vehicle has cleared the facility. Empty containers which last contained a compressed gas referenced to this subsection are not allowed passage when the quantity and/or size limitations exceed those described above. No empty tank vehicle used to transport any compressed gas referenced to this subsection is allowed passage.

(b.2) Housetrailers, camper trailers, self-propelled campers, mobile homes, recreational vehicles, and

other vehicles equipped with LP-gas installations for cooking, heating or refrigeration are permitted to travel across the facility provided: (i) That LP-Gas containers do not exceed two tanks containing not more than 105 pounds water capacity (approximately 45 pounds LPG capacity) each or one cylinder not exceeding 60 pounds LPG capacity. (ii) That containers are constructed, installed, and maintained in accordance with the regulations and specifications of the Department of Transportation and National Fire Protection Association. (iii) That the inspection by authorized facility personnel, reveals LP-Gas containers are properly valved-off, securely attached, and determined to be safe for travel. (iv) The valves must remain closed until vehicle has cleared the facility.

Empty containers which last contained a compressed gas referenced to this subsection are not allowed passage when the quantity and/or size limitations exceed those described above.

(b.3) Passenger vehicles equipped to use ~~LP-Gas~~ *only liquefied petroleum gas (LPG) or compressed natural gas (CNG)* as a *single* motor fuel will be permitted passage, provided that the ~~LP-Gas~~ *LPG or CNG* containers are manufactured, installed, and maintained in keeping with the rules, regulations and specifications of the Department of Transportation ~~and~~ , the National Fire Protection Association , *and the American Gas Association* and further provided that such containers do not exceed 200 gallons water capacity.

Trucks or commercial vehicles equipped to use ~~LP-Gas~~ *only LPG or CNG* as *single* motor fuel will be permitted passage, provided that the ~~LP-Gas~~ *LPG or CNG* containers are manufactured, installed, and maintained in keeping with the rules, regulations and specifications of the Department of Transportation ~~and~~ , the National Fire Protection Association , *and the American Gas Association* and further provided that such containers do not exceed 300 gallons water capacity. Empty containers which last contained a compressed gas referenced to this subsection are not allowed passage when the quantity and/or size limitations exceed those described above.

VIRGINIA HOUSING DEVELOPMENT AUTHORITY

NOTICE: The Virginia Housing Development Authority is exempted from the Administrative Process Act (§ 9-6.14:1 et seq. of the Code of Virginia); however, under the provisions of § 9-6.14:22, it is required to publish all proposed and final regulations.

Title of Regulation: **VR 400-02-0016. Rules and Regulations for Allocation of Elderly and Disabled Low-Income Housing Tax Credits.**

Statutory Authority: §§ 36-55.30:3 and 58.1-339 of the Code of Virginia.

Public Hearing Date: N/A – Written comments may be submitted until June 12, 1992.
(See Calendar of Events section for additional information)

Summary:

The proposed amendments will (i) expand the rules and regulations for allocation of elderly and disabled low-income housing tax credits to include single family homes and other types of structures having no comparable units in the same property, (ii) make certain changes in the requirements for eligibility of owners, tenants and units under the rules and regulations, (iii) amend certain definitions, and (iv) make other clarifying changes and technical corrections.

VR 400-02-0016. Rules and Regulations for Allocation of Elderly and Disabled Low-Income Housing Tax Credits.

§ 1. Definitions.

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

~~*"Applicant"* means an applicant for tax credits under these rules and regulations and, upon and subsequent to an allocation of such credits, also means the owner of the tax credit unit to whom the tax credits are allocated.~~

"Authority" means the Virginia Housing Development Authority.

"Board" means the Board of Commissioners of the authority.

~~*"Disabled"*~~*"Disability"* means (i) a physical or mental impairment which substantially limits one or more of the major life activities of such individual and includes any physiological disorder or condition, cosmetic disfigurement or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive; digestive; genito-urinary; hemic and lymphatic; skin; and endocrine; or any mental or psychological disorder such as mental retardation, organic brain syndrome, emotional or mental illness and specific learning disabilities (the term "physical or mental impairment" includes, but is not limited to, such diseases and conditions as orthopedic, visual, speech and hearing impairments, cerebral palsy, autism, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, Human Immunodeficiency Virus (HIV) infection, mental retardation, emotional illness, drug addiction (other than addiction caused by current, illegal use of a controlled substance) and alcoholism) or (ii) a record of

such an impairment; or being regarded as having such an impairment which includes a history of or being misclassified as having a mental or physical impairment that substantially limits one or more major life activities; or a physical or mental impairment that does not substantially limit one or more major life activities but that is treated by another person as constituting such a limitation; or a physical or mental impairment that substantially limits one or more major life activities only as a result of the attitudes of others toward such impairment; or none of the impairments defined above but *the individual* is treated by another person as having such an impairment *; provided, however, that any physical or mental impairment described in (i) or (ii) shall be expected to result in death or shall have lasted continuously during the immediately preceding 12-month period or shall be expected to last continuously during the next succeeding 12-month period .*

~~*"Disabled person"* means a person who is disabled as defined herein.~~

~~*"Disabled household"* means a household in which any one or more members are disabled.~~

"Elderly person" means a person who exceeds, by any period of time, 62 years of age.

~~*"Elderly household"* means a household of which the head or the head's spouse is elderly. The household may be two or more elderly persons who are not related or one or more such persons living with someone essential to their care or well-being.~~

"Elderly tenant" means (i) an elderly person or (ii) a household in which any member is an elderly person.

"Eligible ~~applicant~~ owner" means any person meeting the criteria for an eligible ~~applicant~~ *owner* as set forth in the state code and these rules and regulations.

"Eligible tenant" means an elderly tenant or tenant with a disability whose income does not exceed the limit described in these rules and regulations.

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

"HUD fair market rent" means the rent published by the U.S. Department of Housing and Urban Development for the Section 8 Rental Certificate Program.

"Income" means gross income (including but not limited to all salary, wages, bonuses, commissions, income from self-employment, interest, dividends, alimony, rental income, pensions, business income, annuities, social security payments, cash public assistance, support payments, retirement income and any other sources of cash income) which is being received by the ~~elderly or disabled person or household (excluding~~ *elderly tenant or tenant with a disability or is regularly paid to or on behalf of such tenant by a third party as of the application date. The income of* any person who is living with an ~~elderly or disabled person and who is essential~~ *elderly person or person with a disability for the primary purpose of providing care* to such ~~elderly or disabled person's well-being) as of the application date~~ *person shall be excluded* . All such ~~earnings~~ *income* , provided ~~they are~~ *it is* not temporary, shall be computed on an annual basis to determine income for the purpose of program eligibility.

~~*"Income eligible elderly or disabled person or household"* means an elderly or disabled person or household whose income does not exceed the limits set forth in these rules and regulations.~~

"Market rent" means the amount of rent, as determined by the authority pursuant to these rules and regulations, charged to other tenants for comparable units (other than tax credit units) in the same property or, if there are no such comparable units in the same property, for comparable units in the same market area.

"Owner" means an applicant for tax credits under these rules and regulations and, upon and subsequent to an allocation of such credits, means the owner of the tax credit unit to whom the tax credits are allocated.

"Person with a disability" means a person having c disability as defined in these rules and regulations.

"Program" means the elderly and disabled low-income housing tax credit program described in these rules and regulations.

"State code" means Article 3 of Chapter 3 of Title 58.1 of the Code of Virginia.

"Tax credit rent" means the reduced amount of rent charge for the tax credit unit to the eligible tenant. As provided in § 3 hereof, the tax credit rent shall be at least 15% less than the market rent.

"Tax credits" means the tax credits as described in § 58.1-339 of the Code of Virginia;

"Tax credit unit" means a unit occupied or to be occupied by ~~income~~ eligible ~~elderly or disabled persons or households~~ *tenants* at reduced rents in order *for the owner* to be entitled to *receive* tax credits hereunder.

"Tenant" means a person or household who is applying for occupancy of, or is occupying, a tax credit unit.

"Tenant with a disability" means (i) a person with a disability or (ii) a household in which any member is a person with a disability.

§ 2. Purpose and applicability.

The following rules and regulations will govern the allocation by the authority of tax credits pursuant to the state code.

Notwithstanding anything to the contrary herein, acting at the request or with the consent of the ~~applicant for tax credits~~ *owner* , the executive director is authorized to waive or modify any provision herein where deemed appropriate by him for good cause, to the extent not inconsistent with the state code.

The rules and regulations set forth herein are intended to provide a general description of the authority's processing requirements and are not intended to include all actions involved or required in the processing and administration of the tax credits. These rules and regulations are subject to change at any time by the authority and may be supplemented by policies, rules and regulations adopted by the authority from time to time.

Notwithstanding anything to the contrary herein, all procedures and requirements in the state code must be complied with and satisfied.

§ 3. General description.

The state code has been amended by adding a section numbered 58.1-339 relating to a tax credit for ~~landlords~~ *owners* providing rent reduction for ~~low-income elderly and disabled persons or households~~ *eligible tenants* .

Beginning January 1, 1991, through December 31, 1993, any individual or corporation receiving an allocation of tax credits pursuant to § 7 hereof shall, subject to the provisions of the state code and these rules and regulations, be entitled to a credit against the tax levied pursuant to § 58.1-320 or § 58.1-400 of the Code of Virginia, provided that the following requirements are satisfied:

1. The individual or corporation is engaged in the business of the rental of dwelling units *(as hereinafter specified)* and *is* subject to the Virginia Residential Landlord and Tenant Act, § 55-248.2 et seq. of the Code of Virginia, ~~whether~~ *either* by virtue of the provisions thereof or by virtue of the ~~applicant's~~ *owner's* providing for the applicability thereof pursuant to § 55-248.5 B of the Code of Virginia;

2. The ~~landlord~~ *owner* provides a reduced rent to ~~income~~ eligible ~~elderly or disabled persons or households~~ *tenants* ; and

3. The rent charged to the ~~income~~ eligible ~~elderly or disabled persons or households~~ *tenants* is at least 15% less than the *market* rent ~~charged to other tenants for comparable units in the same property~~ .

The allowable tax credit amount shall be 50% of the total rent reductions allowed during the taxable year to the ~~income~~ eligible ~~elderly or disabled persons or households~~ *tenants* occupying the tax credit units. The amount of the rent reduction shall be equal to ~~(i)~~ the ~~amount of rent, as determined by the authority, charged to other tenants for comparable units in the same property~~ *market rent* minus ~~(ii)~~ the ~~amount of~~ *tax credit* rent ~~charged for the tax credit unit to the income eligible elderly or disabled person or household. In calculating such rent reduction, it shall be assumed~~ . *For this purpose, the tax credit rent shall include any rental subsidy payable on behalf of the eligible tenant under any governmental or private program.*

If there are comparable units (other than tax credit units) in the same property, the market rent shall be determined by the authority to be the rent charged to other tenants for such comparable units. For the purpose of determining the amount of rent charged to other tenants for comparable units in the same property, the authority shall assume that the other tenants commenced and, if applicable, renewed their leases as of the same date or dates, and for the same term or terms as the ~~income~~ eligible ~~elderly or disabled persons or families~~ *tenants* and at the rents in effect on such date or dates.

If there are no other such comparable units in the same property, then the market rent shall be determined by the authority to be the rent charged for comparable units in the same market area. Such rent shall be (i) the rent most recently charged for the tax credit unit to a person (who may be the eligible tenant to be assisted) unrelated to the owner within the one-year period prior to the date of filing of the application, plus a rental increase in an amount determined by the authority to reflect increases in rents in the market area of such tax credit unit since the date such rent was last charged, or (ii) if no rental history as described in (i) exists, the HUD fair market rent allowed for a comparable unit in the same market area (as reduced, to the extent determined by the authority, for any utilities which are not to be included in the tax credit rent under the terms of the lease); provided, however, that the owner may demonstrate to the authority that the rent for a comparable unit in the same market area is higher than (i) or (ii) above, as applicable, and to the extent so demonstrated to the satisfaction of the authority, such higher rent shall be used.

Notwithstanding anything to the contrary herein, the market rent shall in no event exceed 150% of the HUD fair market rent allowed for comparable units in the same market area (as reduced, to the extent determined by the authority, for any utilities which are not to be included in the tax credit rent under the terms of the lease).

~~The applicant shall not be entitled to an allocation of tax credits for any unit on which any portion of the rent is paid for the benefit of a tenant under any governmental or private program.~~ If the tax credit unit is subsidized or assisted under any ~~other~~ governmental or private program ~~not providing such rental payments~~ , the comparable units *in the same property or market area, as applicable,* shall include only those units similarly subsidized or assisted.

Because the intent of the state code is to provide tax credits for the rental of dwelling units only, tax credits may not be allocated by the authority for the leasing of land *only* , including without limitation mobile home lots. *Tax credits may be allocated for the leasing of both a mobile home lot and the mobile home located thereon.*

To be eligible for the program, a dwelling unit must contain separate and complete facilities for living, sleeping, eating, cooking and sanitation. Such accommodations may be served by centrally located equipment such as air conditioning or heating. Thus, for example, an apartment containing a living area, a sleeping area, bathing and sanitation facilities and cooking facilities equipped with a cooking range, refrigerator and sink, all of which are separate and distinct from other apartments, would constitute a unit.

In order to satisfy the requirement in § 58.1-339 of the state code that the owner be an individual or corporation engaged in the business of the rental of dwelling units, the owner must intend at the time of application and at all times thereafter to report, for federal income tax purposes, all rental and other income and any related expenses of the tax credit unit with respect to each tax year for which the tax credits are to be claimed for such tax credit unit.

The amount of credit for each individual or corporation for each taxable year shall not exceed $10,000 or the total amount of tax imposed by Chapter 3 of Title 58.1 of the Code of Virginia, whichever is less. If the amount of such credit exceeds the taxpayer's tax liability for such taxable year, the amount which exceeds the tax liability may be carried over for credit against income taxes of such individual or corporation in the next five taxable years until the total amount of the tax credit has been taken.

Credits granted to a partnership or an electing small business corporation (S corporation) shall be passed through to the individual partners or shareholders in proportion to their ownership or interest in the partnership or S corporation.

The total amount of tax credits which may be approved by the authority in any fiscal year shall not exceed $1,000,000.

The authority may charge to each ~~applicant~~ *owner* fees in such amount as the executive director shall determine to be necessary to cover the administrative costs to the authority. Such fees shall be payable at such time or times as the executive director shall require.

§ 4. Solicitations of applications.

The executive director may from time to time take such action as he may deem necessary or proper in order to solicit applications for tax credits. Such actions may include advertising in newspapers and other media, mailing of information to prospective applicants and other members of the public, and any other methods of public announcement which the executive director may select as appropriate under the circumstances. The executive director may impose requirements, limitations and conditions with respect to the submission of applications and the selection thereof as he shall consider necessary or appropriate.

§ 5. Application.

Application for an allocation of tax 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 as may be requested by the authority in order to comply with the state code and to make the allocation of the tax credits in accordance with these rules and regulations.

The executive director may establish criteria and assumptions to be used by the ~~applicant~~ *owner* in the calculation of amounts in the application, and any such criteria and assumptions shall be indicated on the application form or instructions.

The executive director may prescribe such deadlines for submission of applications for allocation of tax credits for any calendar year as he shall deem necessary or desirable to allow sufficient processing time for the authority to make such allocations.

The tax credit unit for which an application is submitted may be, but shall not be required to be, financed by the authority. If any such tax credit unit is to be financed by the authority, the application for such financing shall be submitted to and reviewed by the authority in accordance with its applicable rules and regulations.

The authority may consider and approve, in accordance herewith, the allocation of tax credits for tax credit units which the authority may own or may intend to acquire, construct or rehabilitate.

§ 6. Eligibility of tenants and verification.

The occupancy of ~~tax credit~~ units entitled to ~~a~~ tax ~~credit~~ *credits* is limited to ~~elderly or disabled persons or households~~ *elderly tenants or tenants with disabilities* whose ~~income~~ *incomes* , as of initial occupancy of the tax credit unit by such ~~person or household~~ *tenants* (or, if *any* such tax credit unit is occupied by ~~such person or household~~ *such a tenant* on January 1 of the first calendar year for which the tax credits are to be claimed for such tax credit unit, as of such January 1), ~~does~~ *do* not exceed 80% of the median income for the area. Preference in occupancy of tax credit units will be given to ~~elderly or disabled persons or households~~ *eligible tenants* whose ~~income is~~ *incomes are* less than or equal to 50% of the median income for the area. The United States Department of Housing and Urban Development ~~Section~~ 8 income limits *for subsidized programs* , as

adjusted by family size, will be used in determining such 80% and 50% of median income for the area.

~~Applicants~~ *Owners* shall be required to obtain written income verification for ~~elderly or disabled persons or households~~ *eligible tenants* who occupy or are expected to occupy a tax credit unit. The verification of income must be sent by the owner to each employer or the agency providing benefits along with a stamped, self-addressed return envelope. Such verification should then be retained by the ~~applicant~~ *owner* and a copy submitted to the authority *(together* with ~~the~~ *an executed* confirmation of resident eligibility form *and the verification of age or disability)* at the ~~end of the calendar year~~ *time that the eligible tenant is determined by the owner to be income eligible* . Verification of income must be current as of a date no earlier than 90 days prior to the date set forth in the preceding paragraph as of which the income of the ~~elderly or disabled person or household~~ *eligible tenant* is determined for eligibility purposes.

With respect to tax credits claimed for rental of tax credit units to ~~disabled persons or households, applicants~~ *tenants with disabilities, owners* shall be required to obtain a written verification of disability. Verification of said disability may be obtained from a physician, diagnostic or vocational rehabilitation service center or the Social Security Administration.

With respect to tax credits claimed for rental of tax credit units to elderly ~~persons or households, applicants~~ *tenants, owners* must verify the age of all persons claiming to exceed 62 years of age. Verification of Social Security benefits paid on the person's behalf will be acceptable if a birth certificate cannot be obtained; provided, however, that any person receiving ~~survival~~ *survivor* Social Security benefits who does not exceed 62 years of age or ~~disabled~~ *does not have a disability* is not eligible for ~~tax credit~~ occupancy *of a tax credit unit* .

The initial lease term for all ~~income~~ eligible ~~elderly or disabled persons or households~~ *tenants* occupying a tax credit unit may not be less than a 12-month period.

§ 7. Review and selection of application; allocation of tax credits.

Pursuant to the state code, the state is divided into the following low-income housing tax credit allocation areas, each of which shall be allocated the percent share of tax credits set forth below and in the state code:

Allocation Area 1

Percent Share of Tax Credits: 10.79

Planning District: LENOWISCO

Jurisdictions: Norton City, Lee County, Scott County, Wise County

Planning District: Cumberland Plateau

Jurisdictions: Buchanan County, Dickenson County, Russell County, Tazewell County

Planning District: Mount Rogers

Jurisdictions: Bristol City, Galax City, Bland County, Carroll County, Garyson County, Smyth County, Washington County, Wythe County

Planning District: New River Valley

Jurisdictions: Radford City, Floyd County, Giles County, Montgomery County, Pulaski County

Allocation Area 2

Percent Share of Tax Credits: 12.09

Planning District: Fifth

Jurisdictions: Clifton Forge City, Covington City, Roanoke City, Salem City, Alleghany County, Botetourt County, Craig County, Roanoke County

Planning District: Central Virginia

Jurisdictions: Bedford City, Lynchburg City, Amherst County, Appomattox County, Bedford County, Campbell County

Planning District: West Piedmont

Jurisdictions: Danville City, Martinsville City, Franklin County, Henry County, Patrick County, Pittsylvania County

Allocation Area 3

Percent Share of Tax Credits: 6.70

Planning District: Central Shenandoah

Jurisdictions: Buena Vista City, Harrisonburg City, Lexington City, Staunton City, Waynesboro City, Augusta County, Bath County, Highland County, Rockbridge County, Rockingham County

Planning District: Lord Fairfax

Jurisdictions: Winchester City, Clarke County, Frederick County, Page County, Shenandoah County, Warren County

Allocation Area 4

Percent Share of Tax Credits: 20.98

Planning District: Northern Virginia

Jurisdictions: Alexandria City, Fairfax City, Falls Church City, Manassas City, Manassas Park City, Arlington County,

Fairfax County, Loudoun County, Prince William County

Allocation Area 5

Percent Share of Tax Credits: 4.70

Planning District: Rappahannock-Rapidan

Jurisdictions: Culpeper County, Fauquier County, Madison County, Orange County, Rappahannock County

Planning District: Thomas Jefferson

Jurisdictions: Charlottesville City, Albemarle County, Fluvanna County, Greene County, Louisa County, Nelson County

Allocation Area 6

Percent Share of Tax Credits: 5.22

Planning District: Southside

Jurisdictions: South Boston City, Brunswick County, Halifax County, Mecklenburg County

Planning District: Piedmont

Jurisdictions: Amelia County, Buckingham County, Charlotte County, Cumberland County, Lunenburg County, Nottoway County, Prince Edward County

Planning District: Crater

Jurisdictions: Colonial Heights City, Emporia City, Hopewell City, Petersburg City, Dinwiddie County, Greensville County, Prince George County, Surry County, Sussex County

Allocation Area 7

Percent Share of Tax Credits: 12.68

Jurisdictions: Richmond City, Charles City County, Chesterfield County, Goochland County, Hanover County, Henrico County, New Kent County, Powhatan County

Allocation Area 8

Percent Share of Tax Credits: 5.15

Planning District: RADCO

Jurisdictions: Fredericksburg City, Caroline County, King George County, Spotsylvania County, Stafford County

Planning District: Northern Neck

Jurisdictions: Lancaster County, Northumberland County, Richmond County, Westmoreland County

Planning District: Middle Peninsula (not including Gloucester)

Jurisdictions: Essex County, King and Queen County, King William County, Mathews County, Middlesex County

Planning District: Accomack-Northampton

Jurisdictions: Accomack County, Northampton County

Allocation Area 9

Percent Share of Tax Credits: 21.69

Planning District: Southeastern Virginia

Jurisdictions: Chesapeake City, Franklin City, Norfolk City, Portsmouth City, Suffolk City, Virginia Beach City, Isle of Wight County, Southampton County

Planning District: Peninsula

Jurisdictions: Hampton City, Newport News City, Poquoson City, Williamsburg City, James City County, York County

Planning District: Middle Peninsula

Jurisdictions: Gloucester County

The executive director may further suballocate these allocation areas into allocation subpools based upon one or more of the following factors: geographical areas; types or characteristics of housing, construction, financing, owners, or occupants; or any other factors deemed appropriate by him to best meet the housing needs of the Commonwealth.

Tax credits shall be allocated to eligible ~~applicants~~ *owners* on a "first-come, first-served" basis. In the event that the amount of tax credits available within an allocation area or subpool is sufficient for some but not all of eligible applications received by the authority on the same day, then the authority shall select one or more of such applications by lot.

The executive director may exclude and disregard any application which he determines is not submitted in good faith.

The amount of tax credits which may be allocated for tax credit units in any single development shall not exceed $10,000; provided, however, that the executive director may from time to time terminate or suspend such $10,000 limit for such allocation area or areas and for such period of time as he shall deem appropriate to assure full utilization and proper distribution of the tax credits. For the purpose of compliance with such $10,000 limit, the executive director may determine that developments in one or more applications constitute a single development based upon such factors as he may deem relevant, including without limitation the ownership, proximity, age, management, financing and physical characteristics of the

developments.

The executive director shall allocate tax credits, in the manner described above, to eligible ~~applicants~~ *owners* within each allocation area or subpool, if applicable, until either all tax credits therein are allocated or all eligible ~~applicants~~ *owners* therein have received allocations. The amount allocated to each such eligible ~~applicant~~ *owner* shall be equal to the lesser of (i) the amount requested in the application or (ii) the amount, determined by the executive director, to which the eligible ~~applicant~~ *owner* is entitled under the state code and these rules and regulations as of the date of application; provided, however, that in no event shall the amount of tax credits so allocated exceed the amount of tax credits available in the allocation area or subpool from which such tax credits are to be allocated.

Amounts in any allocation area not allocated to any eligible ~~applicants~~ *owners* may not be reallocated to any other allocation areas. Any amounts in any allocation subpools not allocated to eligible ~~applicants~~ *owners* shall be reallocated among the other subpools (within the same allocation area) in which eligible ~~applicants~~ *owners* shall not have received allocations in the full amount permissible under these rules and regulations. Such reallocation shall be made pro rata based on the amount originally allocated to all such subpools with excess applications divided by the total amount originally allocated to all such subpools with excess applications. Such reallocations shall continue to be made until either all of the tax credits within the allocation area are allocated to eligible ~~applicants~~ *owners* in the manner described above or all applications in the allocation area have received allocations.

The executive director determines whether the ~~applicant~~ *owner* and the tax credit units are entitled to tax credits under the state code and these rules and regulations. If the executive director determines that the ~~applicant~~ *owner* or the tax credit units are not so entitled to tax credits, the ~~applicant~~ *owner* shall be so informed and his application shall be terminated. If the authority determines that the ~~applicant~~ *owner* and the tax credit units are so entitled to tax credits, then the executive director shall issue to the ~~applicant~~ *owner* , on behalf of the authority, a commitment for allocation of tax credits with respect to the applicable tax credit units. The allocation shall be subject to the approval or ratification thereof by the authority's board as described below.

The board shall review and consider the analysis and recommendation of the executive director for the allocation of tax credits, and, if it concurs with such recommendation, it shall by resolution approve or ratify the allocation by the executive director of the tax credits to the eligible ~~applicant~~ *owner* , subject to such terms and conditions as the board or the executive director shall deem necessary or appropriate to assure compliance with the state code and these rules and regulations. If the board determines not to approve or ratify an allocation of tax credits, the executive director shall so notify the ~~applicant~~ *owner* .

Upon compliance with the state code and these rules and regulations, the ~~applicant~~ *owner* to whom an allocation is made hereunder shall be entitled to tax credits annually, in such amount as is determined by the authority pursuant to these rules and regulations, for each year beginning in the year for which such allocation is made and ending December 31, 1993, unless terminated or reduced pursuant to these rules and regulations.

The executive director may require that ~~applicants~~ *owners* to whom tax credits have been allocated 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 tax credit unit and its compliance with the application and these rules and regulations. If on the basis of such written confirmation and documentation and other available information the executive director determines that the tax credit unit does not or will not qualify or will not continue to qualify for such tax credits, then the executive director may terminate or reduce the allocation of such tax credits. Without limiting the foregoing, the ~~applicant~~ *owner* shall lease the tax credit units to ~~income~~ eligible ~~elderly or disabled persons or households~~ *tenants* at reduced rents such that the aggregate of such rent reductions shall be no less than the aggregate of the rent reductions set forth in the application. In the event that the ~~applicant~~ *owner* shall fail to so lease the tax credit units, the authority may, upon its determination that the ~~applicant~~ *owner* is unable or unwilling to utilize fully its allocation of the tax credits, terminate or reduce such allocation, as it shall deem appropriate.

The authority shall have the right to inspect the tax credit units and related property and improvements from time to time, and the tax credit units and related property and improvements shall be in a state of repair and condition satisfactory to the authority. The authority may require the ~~applicant~~ *owner* to make necessary repairs or improvements, in a manner acceptable to the authority, as a condition for receiving or qualifying for an allocation of tax credits or for certification to the Department of Taxation as described herein below.

The executive director may establish such deadlines for the ~~applicant~~ *owner* to qualify for the tax credits and to comply with the application and these rules and regulations 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~~ *owner's* allocation, to allocate such tax credits to other eligible ~~applicants~~ *owners* .

Any material changes to the condition, use or occupancy of the tax credit unit or in any other representations, facts or information, as contained or proposed in the application, occurring subsequent to the submission of the application for the tax 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 these rules and regulations and the state code, reduce the amount of tax credits allocated 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 allocation of such tax credits or impose additional terms and conditions with respect thereto.

In the event that any allocation of tax credits is terminated or reduced by the executive director under this section, he may allocate such tax credits (in the amount of such termination or reduction) to eligible ~~applicants~~ *owners* (other than the ~~applicants~~ *owners* whose tax credit allocation was so terminated or reduced) in the first-come first-served manner described above or in such other manner as he shall determine consistent with the requirements of the state code.

If subsequent to receipt of an allocation of tax credits an ~~applicant~~ *owner* shall transfer any of the tax credit units to a transferee which is eligible for such tax credits under the state code and these rules and regulations, such transferee shall thereupon be entitled to the allocation of tax credits for such tax credit units and shall, for the purposes of these rules and regulations, be thereafter deemed the ~~applicant~~ *owner* for such tax credits.

§ 8. Tax credit period.

Each period for which an owner may claim tax credits for any tax credit unit shall commence upon the date that the tax credit unit is occupied by an eligible tenant pursuant to a lease providing for a 12-month term and for the payment of rent in the amount of the tax credit rent. Such period shall not commence prior to the allocation of the tax credits by the authority to the owner, except that if the tax credit unit is so occupied from the first day of the month in which the allocation of tax credits is made, such period shall commence on such first day of the month. Such period shall continue until termination of occupancy as described in § 9 hereof. However, in no event shall any such period commence and continue unless the tax credit unit is and remains in a state of repair and condition satisfactory to the authority in accordance herewith, and all other applicable requirements of the state code and these rules and regulations have been and are satisfied. If the owner shall be entitled to claim tax credits on any tax credit unit for a portion of a month during such period, the rent reduction shall be calculated pro rata based upon the number of days in such month that the owner is so entitled to claim tax credits or, with respect to the termination of occupancy, shall be calculated as provided in § 9 hereof.

~~§ 8.~~ *§ 9.* Maintenance of records; submission requirements; termination of occupancy.

~~Applicants~~ *Owners* shall be responsible for obtaining and maintaining all documentation required by the authority to evidence that the tax credit units qualify for tax credits under the program. Owners will be responsible for providing this documentation to the authority for review within 30 days following the end of each calendar year *; provided, however, that the documents listed in subdivisions 2 a, b, c and g of this section shall be submitted at the time required by § 6 hereof* . The tax credit unit will not qualify for tax credits if all required documents, in the form required by the authority, are not ~~available~~ *so provided* . Required documentation to be submitted to the authority includes, but is not limited to, the following:

1. A listing (including dates of occupancy) of all tenants currently occupying, or who previously occupied, a tax credit unit entitled to a tax credit for that year.

2. A complete certification package for each ~~income~~ eligible ~~elderly or disabled person or household~~ *tenant* receiving the reduced rent. The certification must include:

a. A completed and executed confirmation of resident eligibility form.

b. Verification of income.

c. Verification of age or disability.

d. A ~~notarized~~ certification from the tenant verifying:

(1) What unit type/size was occupied,

(2) Number of months said unit was occupied,

(3) The amount of rent paid, and

(4) How many months that amount of rent was paid.

e. A certification of the ~~applicant~~ *owner* that preference in occupancy of the tax credit units was given to ~~elderly or disabled persons or households~~ *eligible tenants* whose ~~income is~~ *incomes are* less than or equal to 50% of the median income for the area (the waiting list for tax credit units during the calendar year identifying the persons applying for such units and their incomes shall be maintained by the ~~applicant~~ *owner* and shall be available for inspection by the authority).

f. Rent rolls for the comparable units in the same property as the tax credit units setting forth the rents charged to other tenants *, if rents for such comparable units are to be used to determine the amount of the rent reduction pursuant to § 3 hereof* .

g. ~~A copy~~ *Copies* of leases for each tax credit unit.

In the event of termination of occupancy, the rent reduction shall be calculated pro rata based upon the number of days determined in the following manner. In the event of death of the only ~~elderly or disabled person~~ *elderly person or person with a disability* occupying a tax credit unit, the ~~applicant~~ *owner* must obtain a copy of the death certificate *or must provide other acceptable documentation of death* ; and the number of days for which an ~~applicant~~ *owner* is entitled to tax credits on such deceased person's tax credit unit shall be determined by the date of death. If the ~~elderly or disabled person or household~~ *eligible tenant* abandons the tax credit unit, the earliest of the date the ~~applicant~~ *owner* discovers the tax credit unit is vacant, the date any utility company terminates service on the tax credit unit, or the date 30 days after abandonment will be used to determine the number of days for which the tax credit unit is entitled to the tax credit. If the tax credit unit shall not be so abandoned but the ~~elderly or disabled person or persons~~ *eligible tenant* shall not occupy the tax credit unit for a period of 30 days (or such longer period of time as the executive director may approve) , the end of such period shall be used to determine the number of days for which the tax credit unit is entitled to the tax credit. If the lease is terminated for any reason other than those set forth above in this paragraph, the effective date of termination shall be used to determine the number of days for which the tax credit unit is entitled to the tax credit.

§ ~~9.~~ *§ 10.* Certification to the Virginia Department of Taxation.

On or before March 15 of each calendar year, the authority shall certify to the Virginia Department of Taxation the name of each ~~applicant~~ *owner* entitled to claim a tax credit for the preceding calendar year and the total amount of tax credits which each such ~~applicant~~ *owner* is entitled to claim under the state code and these rules and regulations and shall further certify that each such ~~applicant~~ *owner* claiming a credit provided the rent reductions as authorized under the state code and these rules and regulations. The ~~applicant~~ *owner* shall be entitled to claim tax credits for such preceding calendar year only in the amount for which the authority makes such certifications.

§ ~~10.~~ *§ 11.* Notification to the Virginia Department of Taxation of noncompliance with state code or these rules and regulations.

If subsequent to the certification in § ~~9~~ *10* the executive director shall become aware of noncompliance with any of the provisions of the state code or these rules and regulations by any ~~applicant~~ *owner* for whom such certification was made and if such noncompliance would result in a reduction in amount of tax credits that such ~~applicant~~ *owner* claimed or could have claimed, the executive director shall, within 90 days, notify the Virginia Department of Taxation of such noncompliance. Such notification shall identify the ~~applicant~~ *owner* and shall describe the noncompliance.

For information concerning Final Regulations, see information page.

Symbol Key

Roman type indicates existing text of regulations. *Italic type* indicates new text. Language which has been stricken indicates text to be deleted. [Bracketed language] indicates a substantial change from the proposed text of the regulations.

CRIMINAL JUSTICE SERVICES BOARD

REGISTRAR'S NOTICE: This regulation is excluded from Article 2 of the Administrative Process Act in accordance with § 9-6.14:4.1 C 4(a) of the Code of Virginia, which excludes regulations that are necessary to conform to changes in Virginia statutory law where no agency discretion is involved. The Criminal Justice Services Board will receive, consider and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: **VR 240-02-2. Regulations Governing the Privacy and Security of Criminal History Record Information Checks for Firearm Purchases.**

Statutory Authority: § 18.2-308.2:2 of the Code of Virginia.

Effective Date: July 1, 1992.

Summary:

These amendments conform to statutory changes brought about by Chapters 637 and 872 of the 1992 Acts of Assembly. Chapter 637 lengthens the period of time for firearms dealers to mail the completed purchaser consent for CHRI check form to the State Police from 24 hours after sale to "On the last day of the week following" sale (§ 2.5 K). Chapter 872 establishes a secondary form of corroboration of identity and residence for the purchase of a firearm by Virginia residents (§ 2.4 C 1 a), establishes a secondary corroboration of identity and residence for non-Virginians purchasing shotguns and rifles (§ 2.4 C 1 b), and provides for non-Virginians to have the capability of obtaining a CHRI check telephonically rather than the previous method which allowed non-Virginians access by mail request alone (§ 2.5 A).

VR 240-02-2. Regulations Governing the Privacy and Security of Criminal History Record Information Checks for Firearm Purchases.

PART I.
GENERAL.

Pursuant to the provisions of § 18.2-308.2:2 of the Code of Virginia, criminal history record information checks are required prior to the sale, rental, trade or transfer of certain firearms. A criminal history record information check shall be requested by licensed dealers from the Department of State Police to determine the legal eligibility of a prospective purchaser to possess or transport certain firearms under state or federal law. The Department of Criminal Justice Services hereby promulgates the following regulations governing these criminal history record information checks as required under § 18.2-308.2:2 H of the Code of Virginia. The purpose of these regulations is to ensure that criminal history record information checks are conducted in a manner which ensures the integrity of criminal history record information, guarantees individual rights to privacy, and supports the needs of law enforcement, while allowing nearly instantaneous sales of firearms to the law abiding public.

§ 1.1. Definitions.

The following words and terms, when used in these regulations, shall have the following meaning unless the context clearly dictates otherwise:

"Antique firearm" means any firearm, including those with a matchlock, flintlock, percussion cap, or similar type of ignition system, manufactured in or before 1898, and any replica of such a firearm, provided such replica: (i) is not designed or redesigned for using rimfire or conventional centerfire fixed ammunition; or (ii) uses rimfire or conventional centerfire fixed ammunition which is no longer manufactured in the United States and which is not readily available in the ordinary channels of commercial trade.

"Criminal history record information" means records and data collected by criminal justice agencies on adult individuals, consisting of notations of arrests, detentions, indictments, informations, or other formal charges and any disposition arising therefrom.

"Criminal history record information check" (also "criminal record check" and "record check") means a review of a potential purchaser's criminal history record information, to be conducted by the Department of State Police at the initiation of a dealer in order to establish a prospective purchaser's eligibility to possess or transport a firearm, as defined herein, under state or federal law.

"Dealer" means any person licensed as a dealer pursuant to 18 U.S.C. § 921 et seq.

"Dealer identification number" (DIN) means a unique identifying number assigned by the Department of State Police to each individual dealer as defined in § 18.2-308.2:2 G of the Code of Virginia, in order to identify such dealers when they request criminal history record information to determine the eligibility of a prospective purchaser to possess or transport a firearm.

"Department" means the Virginia Department of State Police.

"Firearm" means any handgun, shotgun, ~~pistol~~ or rifle which expels a projectile by action of an explosion.

"Handgun" means any firearm including a pistol or revolver designed to be fired by the use of a single hand.

"Law-enforcement officer" means any full-time or part-time employee of a police department or sheriff's office which is a part of or administered by the Commonwealth or any political subdivision thereof, and who is responsible for the prevention and detection of crime and the enforcement of the penal, traffic or highway laws of the Commonwealth, and shall include any member of the Regulatory Division of the Department of Alcoholic Beverage Control vested with police authority, any police agent appointed under § 56-353 of the Code of Virginia (provides railroad officials with the authority to appoint police agents), or any game warden who is a full-time sworn member of the enforcement division of the Department of Game and Inland Fisheries. Part-time employees are compensated officers who are not full-time employees as defined by the employing police department or sheriff's office.

"Prospective purchaser" means an individual who intends to buy, rent, trade, or transfer a firearm or firearms as defined herein, and has notified a dealer of his intent.

"Resident of Virginia" means a person who resides and has a present intent to remain within the Commonwealth, as shown by an ongoing physical presence and a residential address within Virginia. If a person does not reside in Virginia, but is on active duty as a member of the U.S. Armed Forces and Virginia is the person's permanent duty station, the person shall, for the purpose of these regulations, be considered a resident of Virginia.

"Transfer" means to sell, rent, trade, or transfer a firearm as defined herein.

"Virginia Firearms Transaction Record Form" means the form issued by the Department of State Police provided to dealers and required for obtaining a criminal history record check, also known as "SP-65," the "VFTR form" or the "VFTR."

PART II.
REGULATIONS.

§ 2.1. Applicability of regulations concerning criminal history record checks for firearm purchase.

A. These regulations apply to:

1. All licensed dealers in firearms; and

2. The Department of State Police.

B. These regulations shall not apply to:

1. Transactions between persons who are licensed as firearms importers or collectors, manufacturers or dealers pursuant to 18 U.S.C. § 921 et seq.;

2. Purchases by or sale to any law-enforcement officer or agent of the United States, Commonwealth or any local government;

3. Antique firearms; or

4. Transactions in any county, city or town that has a local ordinance adopted prior to January 1, 1987, governing the purchase, possession, transfer, ownership, conveyance or transportation of firearms which is more stringent than § 18.2-308.2:2 of the Code of Virginia.

§ 2.2. Responsibilities of dealers.

It shall be the responsibility of dealers that transfer firearms in Virginia to comply with the following:

1. Register with the department and obtain from the department a dealer identification number (DIN) and the toll-free telephone number to participate in the criminal history record check program.

2. Prior to transferring any firearm, determine if the firearm is a "firearm" as defined in these regulations and § 18.2-308.2:2 of the Code of Virginia.

3. Deny the transfer of a handgun to a non-Virginia resident in accordance with 18 U.S.C. § 922(b)(3).

~~3.~~ *4.* Complete the VFTR form.

~~4.~~ *5.* Request a criminal history record information check prior to the transfer of any such firearm.

6. Request a criminal history record check either by telephone or by mail prior to the sale of shotguns and rifles to non-Virginia residents.

~~5.~~ *7.* Maintain required forms and records according to the procedures outlined in these regulations.

~~6.~~ *8.* Deny the transfer of a firearm if advised by the Department of State Police that the prospective purchaser is ineligible to possess such a firearm and the department disapproved the transfer of a firearm to the prospective purchaser.

~~7.~~ *9.* Allow the Department of Criminal Justice Services access to all forms and records required by these regulations.

§ 2.3. Responsibilities of the Department of State Police.

A. The Department of State Police shall operate a

telephone and mail response system to provide dealers in firearms (as defined herein) with information on the legal eligibility of prospective purchases to possess or transport firearms covered under these regulations. This information shall be released only to authorized dealers. Prior to the release of the information, the identity of the dealer and the prospective purchaser can be reasonably established.

B. In no case shall the department release to any dealer actual criminal history record information as defined herein. The dealer shall only receive from the department a statement of the department's approval or disapproval of the transfer, and an approval code number, if applicable, unique to the transaction. A statement of approval or disapproval shall be based on the department's review of the prospective purchaser's criminal history record information and restrictions on the transfer of firearms to felons enumerated in § 18.2-308.2 of the Code of Virginia or federal law. This statement shall take one of the following two statuses: (i) approval with an approval code number, or (ii) disapproval with no approval code number.

C. The department shall provide to dealers a supply of VFTR forms, a DIN, and a toll-free number to allow access to the telephone criminal history record check system available for approval of firearms purchases ~~by Virginia residents~~ .

D. The department shall supply all dealers in the Commonwealth with VFTR forms in a manner which allows the department to use the forms to identify dealers and monitor dealers' use of the system to avoid illegal access to criminal history records and other department information systems.

E. The department shall hire and train such personnel as are necessary to administer criminal history record information checks, ensure the security and privacy of criminal histories used in such record checks, and monitor the record check system.

F. Allow the Department of Criminal Justice Services access to all forms and record required by these regulations.

§ 2.4. Preparing for a criminal history record check.

A. General procedures.

1. If any firearm which a prospective purchaser intends to obtain in transfer is a firearm as defined herein, the dealer shall request that the Department of State Police conduct a criminal history record check on the purchaser. The dealer may obtain the required record check from the department for purchasers who are residents of Virginia by telephoning the department, using the provided toll-free number, and requesting the record check. For ~~purchasers who are~~ out-of-state residents *who purchase rifles or shotguns* , the dealer may ~~only~~ request the record check from the department by *telephone,* mail or delivery. However, Virginia residents may, if they elect, request the dealer to obtain a record check by mail. The initial required steps of completion of the VFTR, obtaining consent of the purchaser, determining residency and verifying identity are common to both telephone and mail methods of obtaining the record check.

2. The dealer shall request a criminal history record check and obtain the prospective purchaser's signature on the consent portion of the form for each new transfer of a firearm or firearms to a given purchaser. One record check is sufficient for any number of firearms in a given transfer, but once a transaction has been completed, no transfer to the same purchaser shall proceed without a new record check.

3. A criminal history record check shall be conducted prior to the actual transfer of a firearm.

B. Completing section A of the Virginia firearms transaction record: Obtaining consent for a criminal history record information check for firearms purchase.

As a condition of any sale, the dealer shall advise the prospective purchaser to legibly complete and sign section A of a VFTR form.

1. The dealer shall require the prospective purchaser to complete section A of the VFTR form in the prospective purchaser's own handwriting, and without the dealer's assistance. The purchaser shall answer the questions listed and shall complete the items that establish residency and describe identity, including name, sex, height, weight, race, date of birth and place of birth.

2. If the prospective purchaser cannot read or write, section A of the VFTR form may be completed by any person other than the dealer or any employee of the dealer according to the procedures specified on the reverse side of the VFTR form.

3. The dealer shall also obtain the prospective purchaser's signature or, if he cannot read or write, his mark, following the consent paragraph at the bottom of section A, which shall certify that the information supplied by the purchaser in section A is true and correct.

C. Completing section B of the Virginia firearms transaction record: Establishing purchaser identity and residency and dealer identity.

Prior to making a request for a criminal history record information check, the dealer shall complete all of section B of the VFTR form for which the dealer is responsible. Information recorded on the VFTR form shall be sufficient to: (i) reasonably establish a prospective purchaser's identity and determine the residency of the prospective

purchaser; and (ii) identify the dealer.

1. Identify prospective purchaser and determine residency. ~~a~~ The dealer shall determine residency and verify the prospective purchaser's identity as required in section B of the VFTR, by requiring at least two forms of identification *that denote the address of the prospective purchaser* . Only the forms of identification listed ~~below~~ *in this subsection* shall be acceptable ~~forms of identification. At least one of the following forms of identification shall include a recent photograph of the prospective purchaser~~ *to establish identity and residency* .

a. For Virginia residents, other than those basing residency upon active duty status in the Armed Forces of the United States, the primary form of identification shall consist of a valid photo-identification form issued by a governmental agency of the Commonwealth. The secondary form of identification shall include an address identical to that shown on the primary form of identification. Accordingly, the dealer shall require the prospective purchaser to furnish ~~one~~ *a primary* form of identification ~~that contains a recent photograph of the prospective purchaser~~ and at least one other *current* form of identification included in the list below *that corroborates identification and purchaser's residence in Virginia* :

(1) ~~A~~ Valid ~~and current~~ Virginia driver's license or photo-identification card ~~provided~~ *issued* by the Virginia Department of Motor Vehicles ~~or another state's issuing authority~~ ;

(2) A military identification card *accompanied by proof that Virginia is the permanent duty station* ;

~~(3) An immigration card;~~

~~(4) An employment identification card, provided the card shows at least the prospective purchaser's name and place of employment;~~

~~(5)~~ ~~A~~ *(3)* Passport;

~~(6)~~ ~~A~~ *(4)* Voter registration card;

~~(7)~~ *(5)* Evidence of paid personal property tax or real estate taxes;

~~(8) A current~~ *(6)* Automobile registration;

~~(9)~~ ~~A~~ *(7)* Hunting or fishing license;

~~(10) A social security card; or~~

(8) Lease;

(9) Utility or telephone bill;

(10) Bank check; or

(11) Other identification allowed as evidence of residency by Part 178.124 of Title 27, Code of Federal Regulations, and ATF Ruling 79-7.

If, for purposes of these regulations, a prospective purchaser's Virginia residency is based upon active duty status with the Armed Forces of the United States with a permanent duty station in Virginia, the primary form of identification may consist of a military identification card accompanied by proof of permanent duty station within Virginia signed by the station commander or duly designated representative. A secondary form of identification shall also be required, and may consist of either a valid driver's license issued by another state, or one of the items of secondary identification listed in subdivisions C 1 a (3) through (11).

~~b. However, one photo identification shall be sufficient identification of any purchaser of a firearm. The one form of identification shall be issued by a governmental agency of the Commonwealth and shall contain the following information:~~

~~(1) Name;~~

~~(2) Birth date;~~

~~(3) Gender;~~

~~(4) Race; and~~

~~(5) Social security number or any other identification number.~~

b. For non-Virginia residents purchasing shotguns or rifles, the dealer shall require the prospective purchaser to furnish one photo-identification form issued by a governmental agency of the person's state of residence and one other form of identification as provided in subdivision C 1 a, which corroborates the identity and residency shown on the photo-identification form.

c. The dealer will ensure that the form(s) of identification support the listing of the identifying characteristics and the resident's address as supplied by the prospective purchaser in section A of the VFTR.

d. If the dealer discovers any unexplained discrepancy between the two forms of identification (different *addresses*, birth dates, ~~different~~ names), the dealer shall not request a criminal history record check until the prospective purchaser can be adequately identified with two acceptable forms of identification as required.

e. The dealer shall name and identify on the VFTR form the document(s) used to verify the prospective purchaser's identity and residence, and shall record all pertinent identifying numbers on the VFTR form.

f. While the dealer is required to collect sufficient information to establish the prospective purchaser's identity and residency from the form(s) of identification listed above, in no case is the dealer authorized to collect more information on the prospective purchaser than is reasonably required to establish identity and state of residence.

2. Identify dealer. The dealer or his employee shall note on section B of the form:

a. The dealer's or employee's signature;

b. His position title (owner, employee);

c. The trade or corporate name and business address; and

d. The dealer's federal firearms license number.

§ 2.5. Procedures for requesting a criminal history record information check by telephone ~~(Virginia residents only)~~ .

A. Once the prospective purchaser has completed section A of the VFTR form and the dealer has completed the necessary portions of the VFTR form and determined that the prospective purchaser is a resident of Virginia, the dealer shall call the Department of State Police and request a criminal history record information check by telephone for the firearm transfer. *For non-Virginia residents purchasing rifles or shotguns, the dealer may also request a criminal history record check by telephone.* The dealer shall use the toll-free number provided by the Department of State Police. However, no provision of these regulations shall prohibit a Virginia resident from obtaining a written record check through the dealer for any firearm transfer.

B. The dealer shall identify himself to the department by providing his DIN and the printed number on the upper right-hand corner of the VFTR form prepared by the prospective purchaser.

C. The dealer shall allow the department to verify this identifying information. The Department of State Police may disapprove a firearm purchase if the department determines that the identifying information supplied by the dealer is incomplete, incomprehensible or in error, raises a reasonable doubt as to the origin of the call, or is otherwise unusable.

D. The dealer shall then supply to the department over the telephone all identifying data on the prospective purchaser which is recorded on section A of the VFTR, in the order requested by the department. This information shall be transmitted to the department in a discreet and confidential manner, assuring to the extent possible that the identifying data is not overheard by other persons in the dealer's place of business. If the dealer cannot provide sufficient information to allow the department to conduct a criminal history record check, the department will not accept the request on the basis of insufficient information to conduct a check. The department may adopt procedures to appropriately address such occurrences.

E. The Department of State Police will respond to the dealer's request for a criminal history record check by consulting the criminal history record information indexes and files, during the dealer's call. In the event of electronic failure or other difficulties, the department shall immediately advise the dealer of the reason for such delay and provide to the dealer an estimate of the length of such delay.

F. If no evidence of a criminal record or other information is found that would preclude the purchaser from possessing or transporting a firearm under state or federal law, the department will immediately notify the dealer that the transfer may proceed, and will provide the dealer with a unique approval code number, which the dealer shall enter in a clear, visible, and convenient manner on the original of the VFTR form.

G. If the initial search discloses that the prospective purchaser may not be eligible to possess a firearm, the department will notify the dealer that a further check must be completed before the end of the dealer's next business day, to determine if the prospective purchaser has a criminal record that makes him ineligible to possess or transport a firearm under state or federal law. This statement of ineligibility shall then be communicated by the dealer to the prospective purchaser in a discrete and confidential manner, recognizing the individual's rights to the privacy of this information.

H. In any circumstance in which the department must return the dealer's telephone call, whether due to electronic or other failure or in order to allow a further search, the dealer shall await the department's call and make no transfer of a firearm to the individual whose record is being checked until:

1. The dealer receives notification of approval of the transfer by telephone from the department; or

2. The department fails to disapprove the transaction of the prospective purchaser before the end of the next business day.

3. Exception: If the department knows at the time of the dealer's telephone call that it will not be able to respond to the request by the end of the dealer's next business day, it will so notify the dealer. Upon receiving notification, the dealer shall note in a clear and visible manner on the VFTR that the department was unable to respond. The dealer may in such cases complete the transfer immediately after his telephone

call.

I. In the event that the department is unable to immediately respond to the dealer's request for a criminal history record check and the prospective purchaser is also unable to await the department's response to the dealer's request and the department ultimately approves of the transfer, the dealer may transfer any firearm or firearms, as listed on the VFTR form that initiated the request for a record check, to the prospective purchaser, after the receipt of the approval of the transfer from the department. The actual transfer of the firearm shall be accomplished in a timely manner. A second record check shall not be required provided that the actual transfer of the firearm occurs within a time period specified by the department.

J. If the dealer is notified by the department that the prospective purchaser is not eligible to possess or transport a firearm or firearms under state or federal law, and the transfer is disapproved, and if he is so notified before the end of the next business day after his accepted telephone request, the dealer shall not complete the transfer.

K. ~~Within 24 hours of any~~ *On the last day of the week following* transfer of a firearm covered by these regulations ~~to a resident of Virginia~~ on the basis of a telephone inquiry, the dealer shall send by mail or shall deliver to the department the appropriate copies of the VFTR other than the original, with sections A and B)roperly completed. No information on the type, caliber, serial number, or characteristics of the firearms transferred shall be noted on the copies of the VFTR submitted to the department, but the forms shall otherwise be complete. The dealer shall note the date of mailing on the form, or shall have the form date stamped or receive a dated receipt if the dealer delivers the form.

L. After sale check.

1. Following the receipt of the required copies of a completed VFTR form recording a transfer ~~to a Virginia resident~~ , the department shall immediately initiate a search of all data bases in order to verify that the purchaser was eligible to possess or transport the firearm(s) under state or federal law.

2. If the search discloses that the purchaser is ineligible to possess or transport a firearm, the department shall inform the chief law-enforcement officer in the jurisdiction where the transfer occurred and the dealer of the purchaser's ineligibility without delay. The department shall mark "disapproved" on a copy of the VFTR submitted by the dealer after the transfer and return the form by mail to the dealer.

§ 2.6. Procedures for requesting a criminal history record check by mail ~~(required for all non-Virginia residents)~~ .

A. ~~All transfers of firearms to non-Virginia residents require a written request for a record check. For non-Virginia residents, a criminal history record check for firearm transfer cannot be conducted by telephone. However,~~ ~~at~~ *At* the request of a Virginia resident ; or a non-Virginia resident, a dealer may request a record check by mail for ~~any~~ *a* firearm transfer. In either case, the dealer shall follow the procedures as set forth below. *In addition, the dealer shall follow the provisions for establishing identity and residency as set forth in § 2.4 C 1 a and b of these regulations.*

~~B. If a prospective purchaser is not a resident of Virginia or cannot supply sufficient information to establish or verify residency, the dealer shall obtain a record check by mailing or delivering a completed VFTR form to the department.~~

~~C.~~ *B.* The dealer shall mail or deliver to the department the appropriate copies of the completed VFTR form according to procedures established by the department (which shall not describe, list, or note the actual firearms to be transferred) within 24 hours of the prospective purchaser's signing and dating of the consent paragraph in section A of the VFTR form. This shall be evidenced by the dealer's notation of the mailing date on the VFTR, if mailed, or the date stamp of the department on the VFTR form or a receipt provided to the deliverer, if delivered. The original of the completed VFTR form shall be retained at the dealer's place of business.

~~D.~~ *C.* The department will initiate a search only upon receipt of the appropriate copies of the VFTR form at department headquarters. The department may challenge and refuse to accept any VFTR form if there is an unreasonable, extended time period between the date of the mailing and the date of receipt of the copies of the form at the department.

~~E.~~ *D.* Following its search of Virginia and national criminal history record indexes and files, the department will return to the dealer a copy of the VFTR form, marked "approved," or "not approved." When a dealer receives approval, he may transfer any firearm or firearms, as listed on the VFTR form that initiated the request for a record check, to the prospective purchaser, after his receipt of the approval. The actual transfer of the firearm shall be accomplished in a timely manner. A second record check shall not be required provided that the actual transfer of the firearm occurs within a time period specified by the department. If the transfer is disapproved, he is not authorized to transfer any firearm to the prospective purchaser.

~~F.~~ *E.* In the case of written requests for criminal history record check, initiated by the submission of VFTR forms, the dealer shall wait up to 10 days after the mailing date (noted on the form) or delivery date stamp (if not mailed) of the request for written approval from the department, prior to transferring a firearm as defined herein.

~~G.~~ *F.* However, if 10 days elapse from the date the

VFTR form was mailed (as noted on the VFTR form) or delivered to the Department of State Police (as indicated by the date stamped by the department), and the department has not responded to the request initiated by the form by approving or disapproving the transaction proposed, the dealer may complete the transfer to the prospective purchaser on his next business day, after the tenth day, or thereafter, and not be in violation of the law or these regulations. After completion of the transfer in this case, as in all cases, any new or further transfer of firearms not listed on the VFTR form that initiated the request for a record check to the same purchaser will require a new criminal history record check.

§ 2.7. Proper use of the components of the criminal history record check system: Forms, records, toll-free telephone number and DIN.

A. The VFTR forms will be provided to the dealer by the department. VFTR forms shall not be transferred from one dealer to another. All VFTR forms partially completed, torn, defaced or otherwise rendered unusable shall be marked "VOID" and disposed of in a manner which will not allow their reuse. All unused forms shall remain the property of the Department of State Police and shall be returned to the department in the event that a dealer ceases to engage in the transfer of firearms in a manner which is regulated by the Department of Criminal Justice Services.

B. The dealer will retain the original of the VFTR form for his own files.

C. The dealer shall keep all blank and completed VFTR originals, and all returned copies in a secure area, which will restrict access to the information contained on the VFTR forms to authorized employees only.

D. The department shall retain a copy of all VFTR forms received from dealers according to the procedures outlined below.

1. Approved transfers. Thirty days after the department has notified the dealer of an approved transfer, the department shall destroy the VFTR form still in its possession and all identifiable information collected pertaining to a prospective purchaser.

2. Disapproved transfers. VFTR forms recording a transfer that was not approved shall be maintained by the department in a separate file, maintained by name of prospective purchaser.

a. The information contained in these forms shall be used by the department for legitimate law-enforcement purposes only, and shall be governed by existing regulations concerning the privacy and security of criminal history record information.

b. The department may maintain any other printouts or reports with these copies of the VFTR form, provided they are treated as criminal history record information.

E. The Department of State Police shall maintain a running log of all requests for criminal history record information checks for firearms transfer, which shall include the following:

1. DIN and name of requester;

2. Dealer's transaction number;

3. Approval code number, if sale is approved;

4. Date of telephone request or mailing or delivery date of mail request;

5. Notation of type of record request - either telephone or mail request;

6. Approved or not approved status; and

7. Date of clearance from department file through mailing of VFTR form to the dealer or other final action.

F. A log shall be retained at the department on each request which leads to approvals of firearm transfers for 12 months from the date of each request.

G. Requests which lead to disapprovals shall be maintained by the department on a log for a period of two years from the date the request was accepted by the department for processing.

H. The department shall monitor and distribute all VFTR forms in an appropriate manner to ensure their proper control and use. This includes designing, redesigning, numbering, distributing, tracking, and processing all VFTR forms.

I. No dealer shall provide his DIN or the toll-free number to another party for any reason.

J. The DIN's and the toll-free number may be changed periodically to ensure that these numbers are not improperly used by unauthorized dealers or unauthorized parties.

§ 2.8. Audits.

A. The Department of State Police shall continuously observe compliance with requirements regarding VFTR form completion, notification of the Department of State Police following firearm transfers, form management and storage, and confidentiality and proper use of the DIN and the toll-free telephone number for Virginia resident telephone record checks.

B. The Department of State Police shall notify the

Department of Criminal Justice Services if a dealer has used or may have used the criminal history record information check system improperly in a manner that may jeopardize the confidentiality and security of criminal history record information systems.

C. Upon such notification, the Department of Criminal Justice Services shall audit the dealership in question and recommend corrective action without delay.

1. Pending the outcome of an audit, the department may invalidate a particular DIN to ensure the continuous integrity of the criminal history record information. Prior to such invalidation, the department shall notify the dealer orally, telephonically or in writing of the reasons for such invalidation and allow the dealer the opportunity to respond. The department shall also notify the Department of Criminal Justice Services when a DIN has been invalidated.

2. Should the results of an audit reveal that the provisions of these regulations have not been violated, the Department of Criminal Justice Services shall advise the department to immediately reinstate the invalidated DIN.

3. Should the results of an audit reveal minor violations of the provisions of these regulations, the Department of Criminal Justice Services may notify the department to monitor all future requests of the dealer for criminal history record checks for a period not to exceed 90 days. In the event that the DIN of the dealer has been invalidated, the Department of Criminal Justice Services shall also notify the department to reinstate the invalidated DIN. Any additional violations that may occur during this time period shall be reported to the Department of Criminal Justice Services. Occurrences of additional violations shall invoke the provisions of these regulations for the handling of major or repeated violations, as outlined below, and may result in a subsequent audit of the dealer.

4. Should the results of an audit reveal major or repeated violations of the provisions of these regulations, the Department of Criminal Justice Services shall advise the department to invalidate the DIN if not invalidated previously and that the invalidated DIN should not be reinstated until the dealer submits a written request to the Department of Criminal Justice Services for reinstatement of the DIN. The request shall demonstrate to the reasonable satisfaction of the Department of Criminal Justice Services that corrective action has been taken by the dealer to comply with the provisions of these regulations.

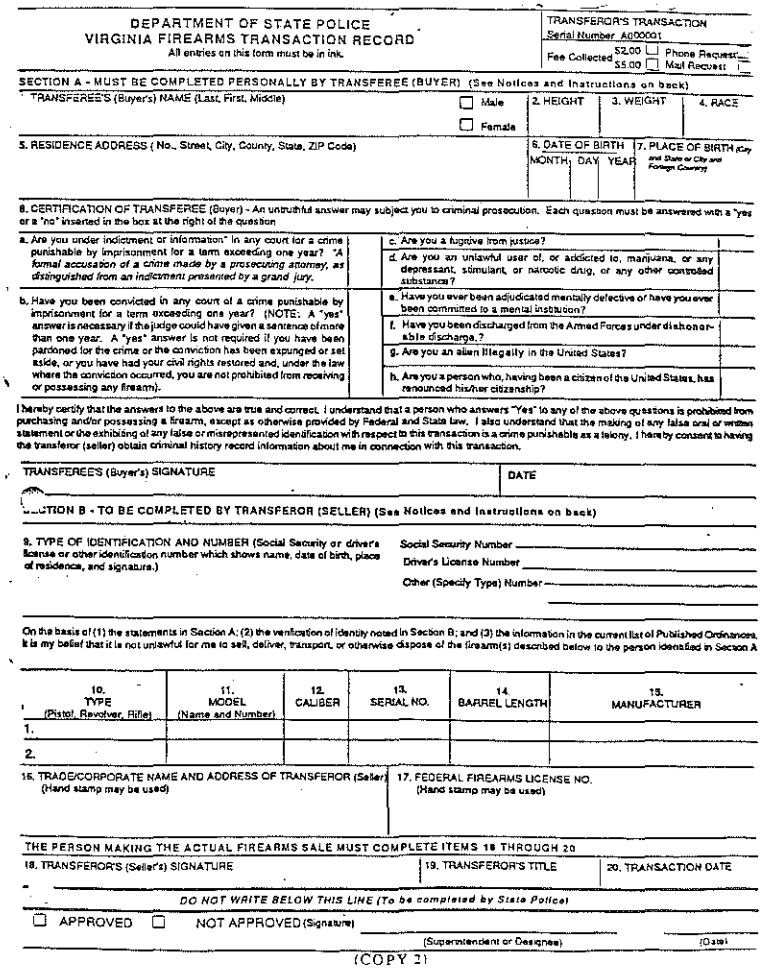
5. Should the results of an audit reveal that the privacy and security of criminal history record information have been compromised, the Department of Criminal Justice Services shall send written notification to the dealer, the office of the local commonwealth's attorney and the department.

D. The Department of Criminal Justice Services shall annually audit the Department of State Police to ensure the following:

1. That records, VFTR's and other materials, except for the maintenance of the log as outlined above, on purchasers found to be eligible to possess or transport firearms (approved) are being routinely destroyed 30 days from the notification, mailing or delivery date of the accepted request for a record check; and

2. That VFTR's and other materials gathered on persons found to be ineligible to purchase a firearm (disapproved) are governed by the regulations for criminal history record information; and

3. That logs recording the approvals and disapprovals of firearm transfers are being correctly maintained according to the provisions of these regulations.



DEPARTMENT OF STATE POLICE
VIRGINIA FIREARMS TRANSACTION RECORD
All entries on this form must be in ink.

TRANSFEROR'S TRANSACTION Serial Number A000001
Fee Collected $2.00 ☐ Phone Request $5.00 ☐ Mail Request

SECTION A - MUST BE COMPLETED PERSONALLY BY TRANSFEREE (BUYER) (See Notices and Instructions on back)

1. TRANSFEREE'S (Buyer's) NAME (Last, First, Middle) ☐ Male ☐ Female | 2. HEIGHT | 3. WEIGHT | 4. RACE

5. RESIDENCE ADDRESS (No., Street, City, County, State, ZIP Code) | 6. DATE OF BIRTH MONTH DAY YEAR | 7. PLACE OF BIRTH (City and State or City and Foreign Country)

8. CERTIFICATION OF TRANSFEREE (Buyer) - An untruthful answer may subject you to criminal prosecution. Each question must be answered with a "yes" or a "no" inserted in the box at the right of the question

a. Are you under indictment or information* in any court for a crime punishable by imprisonment for a term exceeding one year? *A formal accusation of a crime made by a prosecuting attorney, as distinguished from an indictment presented by a grand jury.*

b. Have you been convicted in any court of a crime punishable by imprisonment for a term exceeding one year? (NOTE: A "yes" answer is necessary if the judge could have given a sentence of more than one year. A "yes" answer is not required if you have been pardoned for the crime or the conviction has been expunged or set aside, or you have had your civil rights restored and, under the law where the conviction occurred, you are not prohibited from receiving or possessing any firearm).

c. Are you a fugitive from justice?

d. Are you an unlawful user of, or addicted to, marijuana, or any depressant, stimulant, or narcotic drug, or any other controlled substance?

e. Have you ever been adjudicated mentally defective or have you ever been committed to a mental institution?

f. Have you been discharged from the Armed Forces under dishonorable discharge,?

g. Are you an alien illegally in the United States?

h. Are you a person who, having been a citizen of the United States, has renounced his/her citizenship?

I hereby certify that the answers to the above are true and correct. I understand that a person who answers "Yes" to any of the above questions is prohibited from purchasing and/or possessing a firearm, except as otherwise provided by Federal and State law. I also understand that the making of any false oral or written statement or the exhibiting of any false or misrepresented identification with respect to this transaction is a crime punishable as a felony. I hereby consent to having the transferor (seller) obtain criminal history record information about me in connection with this transaction.

TRANSFEREE'S (Buyer's) SIGNATURE | DATE

SECTION B - TO BE COMPLETED BY TRANSFEROR (SELLER) (See Notices and Instructions on back)

9. TYPE OF IDENTIFICATION AND NUMBER (Social Security or driver's license or other identification number which shows name, date of birth, place of residence, and signature.)
Social Security Number
Driver's License Number
Other (Specify Type) Number

On the basis of (1) the statements in Section A; (2) the verification of identity noted in Section B; and (3) the information in the current list of Published Ordinances, it is my belief that it is not unlawful for me to sell, deliver, transport, or otherwise dispose of the firearm(s) described below to the person identified in Section A

10. TYPE (Pistol, Revolver, Rifle)	11. MODEL (Name and Number)	12. CALIBER	13. SERIAL NO.	14. BARREL LENGTH	15. MANUFACTURER
1.					
2.					

16. TRADE/CORPORATE NAME AND ADDRESS OF TRANSFEROR (Seller) (Hand stamp may be used)
17. FEDERAL FIREARMS LICENSE NO. (Hand stamp may be used)

THE PERSON MAKING THE ACTUAL FIREARMS SALE MUST COMPLETE ITEMS 18 THROUGH 20

18. TRANSFEROR'S (Seller's) SIGNATURE | 19. TRANSFEROR'S TITLE | 20. TRANSACTION DATE

DO NOT WRITE BELOW THIS LINE (To be completed by State Police)

☐ APPROVED ☐ NOT APPROVED (Signature) (Superintendent or Designee) (Date)

(COPY 2)

DEPARTMENT OF HOUSING AND COMMUNITY DEVELOPMENT (BOARD OF)

REGISTRAR'S NOTICE: The following regulation is exempted from the Administrative Process Act under the provisions of § 9-6.14:4.1 B 4 of the Code of Virginia, which excludes agency action relating to grants of state or federal funds or property.

Title of Regulation: **VR 394-01-107. Procedures for Allocation of Low-Income Housing Tax Credits.**

Statutory Authority: § 42 of the Internal Revenue Code; §§ 36-143, 36-146 and 36-147 of the Code of Virginia; and Governor's Executive Order No. Forty (91).

Effective Date: July 1, 1992.

Summary:

These procedures establish the administrative framework for the allocation of low income housing tax credits by the Department of Housing and Community Development. Since their initial publication in 8:11 VA.R. 1720-1734 February 24, 1992, the procedures have been changed to include language related to monitoring projects for noncompliance with the provisions of § 42 of the IRC. The change was made in order to comply with regulations proposed by the Internal Revenue Service on December 27, 1991.

These procedures supercede the regulations published by the Virginia Housing Development Authority in 8:7 VA.R. 1123 December 30, 1991.

VR 394-01-107. Procedures for Allocation of Low-Income Housing Tax Credits.

§ 1. Definitions.

The following words and terms, when used in these procedures, shall have the following meaning, unless the context clearly indicates otherwise:

"Applicant" means an applicant for federal credits or state credits, or both, under these procedures and, upon and subsequent to an allocation of such credits, also means the owner of the development to whom the federal credits or state credits, or both, are allocated.

"Estimated highest per bedroom credit amount for new construction units" means, in subdivision 6 of § 6, the highest amount of federal credits and 50% of state credits estimated by the director to be allocated per bedroom (within the low-income housing units) to any development in the Commonwealth (or, if the director shall so determine, in each pool or subpool) composed solely of new construction units.

"Estimated highest per bedroom credit amount for rehabilitation units" means, in subdivision 6 of § 6, the highest amount of federal credits and 50% of state credits estimated by the director to be allocated per bedroom (within the low-income housing units) to any development in the Commonwealth (or, if the director shall so determine, in each pool or subpool) composed solely of rehabilitation units.

"Estimated highest per unit credit amount for new construction units" means, in subdivision 5 of § 6, the highest amount of federal credits and 50% of state credits estimated by the director to be allocated per low-income unit to any development in the Commonwealth (or if the director shall so determine, in each pool or subpool) composed solely of new construction units.

"Estimated highest per unit credit amount for rehabilitation units" means, in subdivision 5 of § 6, the highest amount of federal credits and 50% of state credits estimated by the director to be allocated per low-income unit to any development in the Commonwealth (or, if the director shall so determine, in each pool or subpool) composed solely of rehabilitation units.

"Federal credits" means the low-income housing tax credits as described in § 42 of the IRC.

"IRC" means the Internal Revenue Code of 1986, as amended, and the rules, regulations, notices and other official pronouncements promulgated thereunder.

"Low-income housing units" means those units which are defined as "low income units" under § 42 of the IRC.

"Qualified low-income buildings" or "qualified low-income development" means the buildings or development which meets the applicable requirements in § 42 of the IRC to qualify for an allocation of federal credits thereunder.

"Single-room occupancy units (SRO)" means permanent facilities for the homeless, consisting of a single room housing unit with either private or shared bath facilities with the optional provision of kitchen facilities.

"State code" means Chapter 1.4 of Title 36 of the Code of Virginia.

"State credits" means the low-income housing tax credits as described in the state code.

"Transitional housing" means facilities for the homeless in which the housing units contain sleeping accommodations and kitchen and bathroom facilities and are located in a building which is used exclusively to facilitate the transition of homeless individuals (within the meaning of § 103 of the Stewart B. McKinney Homeless Assistance Act (42 U.S.C. 11302) to independent living within 24 months, and in which a governmental entity or qualified nonprofit organization provides such individuals with temporary housing and supportive services designed to assist such individuals in locating and retainin

permanent housing.

"Virginia taxpayer" means any individual, estate, trust or corporation which, in the determination of the department, is subject to the payment of Virginia income taxes and will be able to claim in full against such taxes the amount of state credits reserved or allocated to such individual, estate, trust or corporation under these procedures.

§ 2. Purpose and applicability.

The following procedures will govern the allocation by the department of federal credits pursuant to § 42 of the IRC and state credits pursuant to the state code.

Notwithstanding anything to the contrary herein, acting at the request or with the consent of the applicant for federal credits or state credits or both, the director is authorized to waive or modify any provision herein where deemed appropriate by him for good cause, to the extent not inconsistent with the IRC and the state code.

The procedures set forth herein are intended to provide a general description of the department's processing requirements and are not intended to include all actions involved or required in the processing and administration of the federal credits and state credits. These procedures are subject to change at any time by the department and may be supplemented by policies and procedures adopted by the department from time to time.

Any determination made by the department pursuant to these procedures as to the financial feasibility of any development or its viability as a qualified low-income development shall not be construed to be a representation or warranty by the department as to such feasibility or viability.

Notwithstanding anything to the contrary herein, all procedures and requirements in the IRC and the state code must be complied with and satisfied.

§ 3. General description.

The IRC provides for federal credits to the owners of residential rental projects comprised of qualified low-income buildings in which low-income housing units are provided, all as described therein. The aggregate amount of such credits (other than federal credits for developments financed with certain tax-exempt bonds as provided in the IRC) allocated in any calendar year within the Commonwealth may not exceed the Commonwealth's annual state housing credit ceiling for such year under the IRC. An amount equal to 10% of such ceiling is set-aside for developments in which certain qualified nonprofit organizations hold an ownership interest and materially participate in the development and operation thereof. Federal credit allocation amounts are counted against the Commonwealth's annual state housing credit ceiling for federal credits for the calendar year in which the federal credits are allocated. The IRC provides for the allocation of the Commonwealth's state housing credit ceiling for federal credits to the housing credit agency of the Commonwealth. The department has been designated by executive order of the Governor as the housing credit agency under the IRC and, in such capacity, shall allocate for each calendar year federal credits to qualified low-income buildings or developments in accordance herewith.

Federal credits may be allocated to each qualified low-income building in a development separately or to the development as a whole in accordance with the IRC.

Federal credits may be allocated to such buildings or development either (i) during the calendar year in which such building or development is placed in service or (ii) if the building or development meets the requirements of § 42(h)(1)(E) of the IRC, during one of the two years preceding the calendar year in which such building or development is expected to be placed in service. Prior to such allocation, the department shall receive and review applications for reservations of federal credits as described hereinbelow and shall make such reservations of federal credits to eligible applications in accordance herewith and subject to satisfaction of certain terms and conditions as described herein. Upon compliance with such terms and conditions and, as applicable, either (i) the placement in service of the qualified low-income buildings or development or (ii) the satisfaction of the requirements of § 42(h)(1)(E) of the IRC with respect to such buildings or the development, the federal credits shall be allocated to such buildings or the development as a whole in the calendar year for which such federal credits were reserved by the department.

Except as otherwise provided herein or as may otherwise be required by the IRC, these procedures shall not apply to federal credits with respect to any development or building to be financed by certain tax-exempt bonds in an amount so as not to require under the IRC an allocation of federal credits hereunder.

The department is authorized by the state code to establish the amount, if any, of state credits to be allocated to any buildings or development qualified for and claiming federal credits. The amount of state credits is calculated as a percentage of federal credits. Such percentage is established by the department as provided herein. The state code provides for a maximum allocation of $3,500,000 state credits in any calendar year. The state credits will be available for buildings or developments for which federal credits shall be allocated in 1990 and subsequent years or, in the case of any development or building to be financed by certain tax-exempt bonds in an amount so as not to require under the IRC an allocation of federal tax credits hereunder, for which such bonds shall be issued in 1990 and subsequent years. In the event that legislation is adopted by the General Assembly to defer the date set forth in §§ 36-55.63 A, 58.1-336 A or 58.1-435 A of the state code, then the year 1990 in the preceding sentence shall likewise be deferred and the

provisions of these procedures relating to state credits shall not become effective until the date set forth in such legislation.

The department shall charge to each applicant fees in such amount as the director shall determine to be necessary to cover the administrative costs to the department, but not to exceed the maximum amount permitted under the IRC. Such fees shall be payable at such time or times as the director shall require.

§ 4. Adoption of allocation plan; solicitations of applications.

The IRC requires that the department adopt a qualified allocation plan which shall set forth the selection criteria to be used to determine housing priorities of the department which are appropriate to local conditions and which shall give certain priority to and preference among developments in accordance with the IRC. The director from time to time may cause housing needs studies to be performed in order to develop the qualified allocation plan and, based upon any such housing needs study and any other available information and data, may direct and supervise the preparation of and approve the qualified allocation plan and any revisions and amendments thereof in accordance with the IRC. The IRC requires that the qualified allocation plan be subject to public approval in accordance with rules similar to those in § 147(f)(2) of the IRC. The director may include all or any portion of these procedures in the qualified allocation plan.

The director may from time to time take such action as he may deem necessary or proper in order to solicit applications for federal credits and state credits. Such actions may include advertising in newspapers and other media, mailing of information to prospective applicants and other members of the public, and any other methods of public announcement which the director may select as appropriate under the circumstances. The director may impose requirements, limitations and conditions with respect to the submission of applications and the selection thereof as he shall consider necessary or appropriate.

§ 5. Application.

Application for a reservation of federal credits or state credits or both shall be commenced by filing with the department an application, on such form or forms as the director may from time to time prescribe or approve, together with such documents and additional information as may be requested by the department in order to comply with the IRC, the state code and these procedures and to make the reservation and allocation of the federal credits and state credits in accordance with these procedures. The application shall include a breakdown of sources and uses of funds sufficiently detailed to enable the department to ascertain where and 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 must be included in the application: 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.

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, provided that such option or contract shall have no conditions within the discretion or control of such owner of such site. No application shall be considered for a reservation or allocation of federal credits or state credits unless such evidence is submitted with the application and the department 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.

The application shall 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 apply (or which the applicant expects to apply) with respect to each building or development. The director may also require the submission of a legal opinion or other assurances satisfactory to the 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 director, setting forth the calculation of the amount of federal 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 federal credits requested.

The 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 shall be indicated on the application form or instructions.

The director may prescribe such deadlines for submission of applications for reservation and allocation of federal credits and state credits for any calendar year as he shall deem necessary or desirable to allow sufficient processing time for the department to make such reservations and allocations.

After receipt of the applications, the department 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 individuals 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 department. If any such development is to be financed by the department, the application for such financing shall be submitted to and received by the department in accordance with its applicable procedures.

The department may consider and approve, in accordance herewith, both the reservation and the allocation of federal credits and state credits to buildings or developments which the department may own or may intend to acquire, construct or rehabilitate.

§ 6. Review and selection of applications; reservation of federal credits.

The director may divide the amount of federal credits into separate pools and may further subdivide those pools into subpools. The division of such pools and subpools may be based upon one or more of the following factors: geographical areas of the Commonwealth; types or characteristics of housing, construction, financing, owners, or occupants; or any other factors deemed appropriate by him to best meet the housing needs of the Commonwealth.

An amount, as determined by the director, not less than 10% of the Commonwealth's annual state housing credit ceiling for federal credits, shall be available for reservation and allocation to buildings or developments with respect to which the following requirements are met:

1. With respect to all reservations and allocations of federal credits, a "qualified nonprofit organization" (as described in § 42(h)(5)(C) of the IRC) is to materially participate (within the meaning of § 469(h) of the IRC) in the development and operation of the development throughout the "compliance period" (as defined in § 42(i)(1) of the IRC); and

2. With respect to only those reservations of federal credits made by the director on or after December 18, 1990, and with respect to only those allocations made pursuant to such reservations, (i) the "qualified nonprofit organization" described in the preceding subdivision 1 is to own an interest in the development (directly or through a partnership) as required by the IRC; (ii) such qualified nonprofit organization is to, prior to the allocation of federal credits to the buildings or development, own a general partnership interest in the development which shall constitute not less than 51% of all of the general partnership interests of the ownership entity thereof (such that the qualified nonprofit organizations have at least a 51% interest in both the income and profit allocated to all of the general partners and in all items of cashflow distributed to the general partners) and which will result in such qualified nonprofit organization receiving not less than 51% of all fees, except builder's overhead and builder's profit, paid or to be paid to all of the general partners (and any other entities determined by the department to be related to or affiliated with one or more of such general partners) in connection with the development; (iii) the director of the department shall have determined that such qualified nonprofit organization is not affiliated with or controlled by a for-profit organization; and (iv) the director of the department shall have determined that the qualified nonprofit organization was not or will not be formed by one or more individuals or for-profit entities for the principal purpose of being included in any nonprofit pools or subpools (as defined below) established by the director. In making the determination required by this subdivision 2(iv), the 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 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, and 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. The director may include in the application of the foregoing factors any other nonprofit organizations which, 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 holds stock satisfies such requirements.

The applications shall include such representations and warranties and such information as the 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 federal credits be available for developments other than those satisfying the preceding requirements. The director may establish such pools or subpools ("nonprofit pools or subpools") of federal credits as he may deem appropriate to satisfy the foregoing requirement. If any such nonprofit pools or subpools are so established, the director may rank the applications therein and reserve federal credits (and, if applicable, state credits) to such applications before ranking

applications and reserving federal credits (and, if applicable, state credits) in other pools and subpools, and any such applications in such nonprofit pools or subpools not receiving any reservations of federal credits (and, if applicable, state credits) or receiving such reservations in amounts less than the full amount permissible hereunder (because there are not enough federal credits then available in such nonprofit pools or subpools to make such reservations) shall be assigned to such other pool or subpool as shall be appropriate hereunder; provided, however, that if federal credits are later made available (pursuant to the IRC or as a result of either a termination or reduction of a reservation of federal credits made from any nonprofit pools or subpools or a rescission in whole or in part of an allocation of federal credits made from such nonprofit pools or subpools or otherwise) for reservation and allocation by the department during the same calendar year as that in which applications in the nonprofit pools or subpools have been so assigned to other pools or subpools as described above, the director may, in such situations, designate all or any portion of such additional federal credits for the nonprofit pools or subpools (or for any other pools or subpools as he shall determine) and may, if additional federal credits have been so designated for the nonprofit pools or subpools, reassign such applications to such nonprofit pools or subpools, rank the applications therein and reserve federal credits to such applications in accordance with the IRC and these procedures. In the event that during any round (as authorized hereinbelow) of application review and ranking the amount of federal credits reserved within such nonprofit pools or subpools is less than the total amount of federal credits made available therein, the director may either (i) leave such unreserved federal credits in such nonprofit pools or subpools for reservation and allocation in any subsequent round or rounds or (ii) redistribute, to the extent permissible under the IRC, such unreserved federal credits to such other pools or subpools as the director shall designate and in which there are or remain applications for federal credits which have not then received reservations therefor in the full amount permissible hereunder (which applications shall hereinafter be referred to as "excess applications") or (iii) carry over such unreserved federal 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. Any redistribution made pursuant to clause (ii) above shall be made pro rata based on the amount originally distributed to each such pool or subpool with excess applications divided by the total amount originally distributed to all such pools or subpools with excess applications. Notwithstanding anything to the contrary herein, no allocation of credits shall be made from any nonprofit pools or subpools 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 subpools may receive a reservation or allocation of credits from any nonprofit pools or subpools, or any combination of those pools with other pools, in an amount greater than $500,000. For the purposes of implementing this limitation, the director may determine that more than one application for more than one development which he deems to be a single development shall be considered as a single application.

The director may elect to allocate no more than $1,000,000 in annual tax credits to any new construction project until all other eligible projects within the applicable pool have received an allocation of credits.

The department shall review each application, and, based on the application and other information available to the department, shall assign points to each application as follows:

1. The extent to which the project addresses Public Purpose. This category carries a maximum of 350 points. Of those:

A maximum of 50 points may be earned based upon the Type of Project, with 50 points for new construction, 50 points for substantial rehabilitation (greater than $15,000/unit), 50 points for acquisition of a HUD expiring use project, and 15 points for moderate rehabilitation (greater than $3,000/unit);

A maximum of 30 points may be earned for Documented Local Need;

A maximum of 30 points may be earned for Local Support, with 15 points for a letter of support from the local government's chief executive officer that states without qualification or limitation, the following:

"The construction or rehabilitation of (name of development) and the allocation of federal housing tax credits available under IRC § 42 for that development will help meet the housing needs and priorities of (name of locality). Accordingly, (name of locality) supports the allocation of federal housing tax credits requested by (name of applicant) for that development,"

and up to 15 points for other evidence of support;

A maximum of 30 points may be earned for Project Quality, with up to 10 points for building materials, 10 points for amenities and unit size, and up to 10 points for energy efficiency;

A maximum of 20 points may be earned for Special Needs Preference. Using a weighted average of the number of units, up to 10 points may be earned for elderly housing, where "elderly" means 62 years of age or older, up to 10 points for housing for handicapped persons, and up to 10 points for housing for large families (3 bedrooms or more).

Five points may be earned for giving Leasing Preference to persons from either local housing authority waiting lists or § 8 waiting lists.

A maximum of 25 points may be earned for involvement by a qualified Nonprofit Organization, with 25 points available for projects in which that qualified Nonprofit Organization has a 51% or greater interest, and up to 10 points available for projects in which that qualified Nonprofit Organization has less than a 51% interest.

A maximum of 150 points may be earned for projects with rents below the maximums allowed, or which have low-income restrictions, allocating points as follows:

150 Maximum points for households at 40% of median income

125 Maximum points for households at 50% of median income

100 Maximum points for households at 60% of median income

A maximum of 10 points may be earned for Special Characteristics that add to the overall project quality or public purpose, such as, but not limited to, rehabilitation of an historic structure, coordination with neighborhood revitilization efforts, or special tenant services.

2. The extent to which the project demonstrates Readiness to move forward quickly. This category carries a maximum of 150 points. Of those:

Five points may be earned for having all required public utilities in place;

A maximum of 25 points may be earned for having appropriate zoning, with 25 for documented appropriate zoning or written evidence satisfactory to the department that no zoning requirements are applicable, 15 for undocumented appropriate zoning if no change in use is proposed, and 5 for evidence that application for appropriate zoning is in process;

Ten points may be earned for having an approved plan of development or written evidence that such a plan is not required;

A maximum of 20 points may be earned for the degree to which the project's plans and specifications (where the project is a new construction project or a rehabilitation project involving major reconfiguration), or work write-ups and specifications (where the project is a rehabilitation project not involving major reconfiguration) are complete. This will be calculated by multiplying 20 points by the percentage of completion, as determined typically by a letter from the project's architect or other appropriate third-party professional.

A maximum of 60 points may be earned for having financing in place (including documented equity sources), with a maximum of 10 for construction financing (10 for a firm financing commitment, 6 for a conditional commitment, 2 for a letter of intent), and a maximum of 50 points divided proportionally between permanent financing and equity sources (50 for a firm financing or equity commitment, 30 for a conditional financial or equity commitment, and 10 for a letter of intent). For the purposes of this section, a firm financing commitment means a written commitment issued by a financial institution or a governmental authority to provide permanent financing for a term of 15 years or more for the proposed development without any conditions within the sole discretion or control of the lender. The director may treat a reservation of funds from the Virginia Housing Partnership Fund as a firm financing commitment. A conditional financing commitment means a written commitment issued by a financial institution or a governmental authority to provide permanent financing for a term of 15 years or more for the proposed development that includes conditions within the sole discretion or control of the lender. A letter of intent means a letter indicating that the lending institution has received and reviewed the project's application for financing, and that the institution has agreed to proceed further with processing. A firm equity commitment means a written commitment issued by a financially sound third party syndicator or third party investor without any conditions within the sole discretion or control of such syndicator or investor. A conditional equity commitment means a written commitment issued by a financially sound third party syndicator or third party investor that includes conditions within the sole discretion or control of such syndicator or investor. A letter of intent means a letter indicating that the third party syndicator or third party investor has received and reviewed the project's application for financing, and that the third party syndicator or third party investor has agreed to proceed further with processing. Such third party syndicator or investor shall neither be directly or indirectly related to nor controlled by the applicant. Notwithstanding the foregoing, in the case of a development comprised of 15 or fewer units only, all or a portion of the aforementioned aggregate amount of funds to be provided for the proposed development may be made available by the applicant or another party if the department receives satisfactory evidence of the availability of those funds;

Five points may be earned for having a Building Permit for the project;

Twenty-five points may be earned for a complete and reasonable time line for putting the project into service.

3. The extent to which the application demonstrates project Financial Workability. This category carries a maximum of 225 points. Of those:

A maximum of 100 points may be earned based on the Completeness (up to 15 points) and Reasonableness (up to 85 points) of the Project Budget, with Reasonableness points being awarded based upon consideration of the cost per unit, debt per unit, estimated cap rate, projected tax credit proceeds, developer's fee, builder overhead and profit, and reserves provided for.

A maximum of 125 points may be earned based on the Completeness (up to 20 points) and Reasonableness (up to 105 points) of the Operating Budget, with Reasonableness points being awarded based upon consideration of factors including but not limited to the rent as a percentage of HUD Fair Market Rents, utility allowance, management fee, maintenance expense per unit, replacement reserve per unit, total operating expenses per unit, and the debt coverage ratio.

4. The extent to which the application demonstrates the Administrative Capacity of the applicants. This category carries a maximum of 100 points. Of those: A maximum of 50 points may be earned for Project Sponsor/Development Team's demonstrated experience, qualifications, and ability to perform their respective functions;

A maximum of 15 points may be earned for Development Team/General Partner Financial strength;

A maximum of 15 points may be earned for Contractor Experience and Financial Strength;

A maximum of 20 points may be earned for Property Management Experience and the Property Management Plan;

A maximum of 25 points may be deducted for failure to address Displacement;

A maximum of 15 points may be deducted for failure to complete the Application, with five points deducted if the correct number of copies is not submitted, and 10 points deducted if all required documentation is not submitted.

5. A maximum of 50 points will be available for scoring the per unit credit amount. For new construction and substantial rehabilitation projects, the number of points awarded shall be determined by multiplying 50 points by the percentage by which the total of the amount of federal credits and 50% of the amount of state credits per low-income housing unit (the "per unit credit amount") of the proposed development is less than the estimated highest per unit credit amount for new construction and substantial rehabilitation projects. For moderate rehabilitation projects, the number of points awarded shall be determined by multiplying 50 points by the percentage by which the total of the amount of federal credits and 50% of the amount of state credits per low-income housing unit (the "per unit credit amount") of the proposed development is less than the estimated highest per unit credit amount for moderate rehabilitation projects. In the case of projects which combine new construction or substantial rehabilitation with moderate rehabilitation, this calculation will use a weighted average based on the number of each unit type in the proposed development.

6. A maximum of 25 points will be available for scoring the per bedroom credit amount. For new construction and substantial rehabilitation projects, the number of points awarded shall be determined by multiplying 25 points by the percentage by which the total of the amount of federal credits and 50% of the amount of state credits per bedroom (the "per bedroom credit amount") of the proposed development is less than the estimated highest per bedroom credit amount for new construction and substantial rehabilitation projects. For moderate rehabilitation projects, the number of points awarded shall be determined by multiplying 25 points by the percentage by which the total of the amount of federal credits and 50% of the amount of state credits per bedroom (the "per bedroom credit amount") of the proposed development is less than the estimated highest per bedroom credit amount for moderate rehabilitation projects. In the case of projects which combine new construction or substantial rehabilitation with moderate rehabilitation, this calculation will use a weighted average based on the number of each unit type in the proposed development.

For the purpose of calculating the points to be assigned pursuant to such items 5 and 6 above, all credit amounts shall be those requested in the applicable application, and the per unit credit amount and per bedroom credit amount for any building located in a qualified census tract or difficult development area (such tract or area being as defined in the IRC) shall be determined based upon 100% of the eligible basis of such building, in the case of new construction, or 100% of the rehabilitation expenditures, in the case of rehabilitation of an existing building, notwithstanding the use by the applicant of 130% of such eligible basis or rehabilitation expenditures in determining the amount of federal credits as provided in the IRC.

7. Extent to which the application addresses Extended Compliance, Reasonable Intermediary Costs, a Plan to Meet the 10% Carryover Requirement, and Special Needs Preferences. This category carries a maximum of 100 points. Of those:

A maximum of 15 points may be earned for a commitment by the applicant to maintain the development as a qualified low-income housing development beyond the 15-year compliance period as

defined in the IRC; such commitment beyond the end of the 15-year compliance period and prior to the end of the 30-year extended use period (as defined in the IRC) being deemed to represent a waiver of the applicant's right under the IRC to cause a termination of the extended use period in the event the department is unable to present during the period specified in the IRC a qualified contract (as defined in the IRC) for the acquisition of the building by any person who will continue to operate the low-income portion thereof as a qualified low-income building, one point being awarded for each year of compliance beyond 15 years;

A maximum of 40 points may be earned for limiting Intermediary Costs, with the maximum number being awarded for the lowest Efficiency Measure score resulting from the application of the following formulas:

Step 1. Net Equity =

(Project Equity) - (Bridge Loan Interest + Syndication fees and Expenses)

Step 2. Efficiency Measure =

(Construction Cost) / (Net Equity - Front-end Developer's Fee)

where "Front-end Developer's Fee" means any fee withdrawn from the project prior to the first three years following placement in service, less the amount of any loans made by the developer to the project that are not to be repaid within that three-year period.

A maximum of 15 points may be earned for the applicant's Plan to meet the 10% carryover requirement imposed by § 42(h) (1) (E) of the IRC.

Using a weighted average of the total number of units, up to 30 points may be earned for providing either permanent housing (30 points), including single room occupancy facilities, or temporary housing (30 points), including transitional housing, for homeless persons.

In the event of a tie in the number of points assigned to two or more applications within the same pool or subpool, or, if none, within the Commonwealth, and if the amount of federal credits available for reservation to such applications is determined by the director to be insufficient for the financial feasibility of both or, as applicable, all of the developments described therein, the department shall, in order to fully utilize the amount of credits available for reservation within such pool or subpool or, if none, within the Commonwealth select one or more of the applications, by lot, to receive a reservation of federal credits in the lesser of the full amount determined by the director to be permissible hereunder or the amount of federal credits then available in such pool or subpool.

The director may exclude and disregard any application which he determines is not submitted in good faith or which he determines would not be financially feasible.

Upon assignment of points to all of the applications, the director shall rank the applications based on the number of points so assigned. If any pools or subpools shall have been established, each application shall be assigned to a pool or subpool and shall be ranked within such pool or subpool. Those applications assigned more points shall be ranked higher than those applications assigned fewer points.

For each application which may receive a reservation of federal credits, the director shall determine the amount, as of the date of the deadline for submission of applications for reservation of federal 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 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 department to be generated with respect to the development, and the percentage of the federal 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, in his sole discretion, to be reasonable. (If the applicant requests any state credits, the amount of state credits to be reserved to the applicant shall be determined pursuant to § 7 prior to the foregoing determination, and any funds to be derived from such state credits shall be included in the above described sources and uses of funds.) The director shall review the applicant's projected rental income, operating expenses and debt service for the credit period. The 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 federal credit dollar amount used for development costs, other than the costs of intermediaries, as the 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.

At such time or times during each calendar year as the director shall designate, the director shall reserve federal credits to applications in descending order of ranking

within each pool or subpool, if applicable, until either substantially all federal credits therein are reserved or all 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 director, of federal credits remaining in a pool or subpool after reservations have been made, "substantially all" of the federal credits in such pool shall be deemed to have been reserved.) The director may rank the applications within pools or subpools at different times for different pools or subpools and may reserve federal credits, based on such rankings, one or more times with respect to each pool or subpool. The director may also establish more than one round of review and ranking of applications and reservation of federal credits based on such rankings, and he shall designate the amount of federal credits to be made available for reservation within each pool or subpool 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 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 federal credits so reserved exceed the maximum amount permissible under the IRC.

If the amount of federal credits available in any pool is determined by the director to be insufficient for the financial feasibility of the proposed development to which such available federal credits are to be reserved, the director may (i) permit the applicant to modify such proposed development and his application so as to achieve financial feasibility based upon the amount of such available federal credits or (ii), for projects which meet the requirements of § 42(h)(1)(E) of the IRC only, reserve additional federal 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. Any modifications shall be subject to the approval of the director; provided, however, that in no event shall such modifications result in a material reduction in the number of points assigned to the application pursuant to § 6 hereof. The reservation of federal credits from the Commonwealth's annual state housing credit ceiling for the following year shall be made only to proposed developments that rank high enough to receive some federal credits from the state housing credit ceiling for the current year. However, any such reservation shall be in the sole discretion of the director if he determines it to be in the best interest of the Plan. In the event a reservation or an allocation of federal credits from the current year or a prior year is reduced, terminated or cancelled, the director may substitute such federal credits for any federal 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 federal credits reserved within any pools or subpools is less than the total amount of federal credits made available therein during such round, the director may either (i) leave such unreserved federal credits in such pools or subpools for reservation and allocation in any subsequent round or rounds or (ii) redistribute such unreserved federal credits to such other pools or subpools as the director may designate and in which there remain excess applications or (iii) carry over such unreserved federal 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. Any redistribution made pursuant to subparagraph (ii) above shall be made pro rata based on the amount originally distributed to each of such pools or subpools so designated by the director with excess applications divided by the total amount originally distributed to all such designated pools or subpools with excess applications. Such redistributions may continue to be made until either all of the federal credits are reserved or all applications have received reservations.

Within a reasonable time after federal credits are reserved to any applicants' applications, the director shall notify each applicant for such reservations of federal credits either of the amount of federal credits reserved to such applicant's application (by issuing to such applicant a written binding commitment to allocate such reserved federal credits subject to such terms and conditions as may be imposed by the director therein, by the IRC and by these procedures) or, as applicable, that the applicant's application has been rejected or excluded or has otherwise not been reserved federal credits in accordance herewith.

The 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 (and, in the case of state credits, the state code), these procedures 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 § 6 hereof). Upon satisfaction of all such aforementioned requirements (including any post-allocation requirements), such deposit (or a pro rata portion thereof based upon the portion of federal credits and, if applicable, state credits so allocated) 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 director, the applicant is entitled to an allocation of the federal credits under the IRC, these procedures and the terms of any binding commitment that the department would have otherwise issued to such applicant, the director may at that time allocate the federal credits (and, if applicable, state credits) to such qualified low income buildings or development without first providing a reservation of such federal credits (and, if applicable, state credits). This provision in no way limits the authority of the 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 federal credits.

The director may require that applicants to whom federal credits (and, if applicable, state 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 department. If on the basis of such written confirmation and documentation as the director shall have received in response to such a request, or on the basis of such other available information, or both, the director determines any or all of the buildings in the development which were to become qualified low-income buildings will not do so within the time period required by the IRC (and, in the case of state credits, the state code) or will not otherwise qualify for such federal credits (and, if applicable, state credits) under the IRC, these procedures or the binding commitment, then the director may terminate the reservation of such federal credits (and, if applicable, state credits) and draw on any good faith deposit. If, in lieu of or in addition to the foregoing determination, the director determines that any contractual agreements between the applicant and the department have been breached by the applicant, whether before or after allocation of the federal credits, he may seek to enforce any and all remedies to which the department may then be entitled under such contractual agreements.

The director may establish such deadlines for determining the ability of the applicant to qualify for an allocation of federal credits (and, if applicable, state credits) as he shall deem necessary or desirable to allow the department sufficient time, in the event of a reduction or termination of the applicant's reservation, to reserve such federal credits (and, if applicable, state credits) to other eligible applications and to allocate such federal credits pursuant thereto.

Any material changes to the development, as proposed in the application, occurring subsequent to the submission of the application for the federal credits (and, if applicable, state credits) therefor shall be subject to the prior written approval of the director. As a condition to any such approval, the director may, as necessary to comply with these procedures, the IRC, the binding commitment and any other contractual agreement between the department and the applicant, reduce the amount of federal credits (and, if applicable, state 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 director, he may terminate or reduce the reservation of such federal credits (and, if applicable, state credits), impose additional terms and conditions with respect thereto, seek to enforce any contractual remedies to which the department may then be entitled, draw on any good faith deposit, or any combination of the foregoing.

In the event that any reservation of federal credits is terminated or reduced by the director under this section, he may reserve, allocate or carry over, as applicable, such federal credits in such manner as he shall determine consistent with the requirements of the IRC and these procedures.

§ 7. Reservation of state credits.

Each applicant may also request a reservation of state credits in his application for a reservation of federal credits. State credits may be reserved only to those applications (i) to which federal credits have been reserved or (ii) which represent that the applicant will be the owner of any development or buildings to be financed by certain tax-exempt bonds in an amount so as not to require under the IRC an allocation of federal credits hereunder. In the case of (ii) above, the applicant for state credits shall submit an application for federal credits (as well as for state credits), and such application shall be submitted, reviewed, and ranked in accordance with these procedures; provided, however, that a reservation shall be made for the state credits only and not for any federal credits.

In order to be eligible for a reservation and allocation of state credits, the development must be owned by one of the following: (i) an individual who is a Virginia taxpayer, (ii) a corporation (other than an S corporation) which is a Virginia taxpayer, (iii) a partnership or an S corporation in which at least 75% of the state credits received by such partnership or S corporation will be allocated to partners or shareholders who are Virginia taxpayers, or (iv) any other legal entity which is a Virginia taxpayer or, in the case of an entity that is taxed on a pass-through basis with respect to tax credits, in which at least 75% of the state credits received by such entity will be allocated to Virginia taxpayers. If more than one of the foregoing shall be joint owners of the development, then the joint tenancy shall be treated as a partnership for purposes of applying the foregoing ownership test. In the case of tiered partnerships, S corporations, and other entities that are taxed on a pass-through basis with respect to tax credits, the ownership test will be applied by looking through such pass-through entities to the underlying owners. The application shall include such information as the director may require in order to determine the owner or owners of the development and the status of such owner or owners or those owning interests therein as Virginia taxpayers. The prior written approval of the department shall be required for any change in the ownership of the development prior to the end of the calendar year in which all of the buildings in such development shall be placed in service, unless the transferee certifies that it is a Virginia taxpayer or, in the case of a pass-through entity, that 100% of its owners of such entity are Virginia taxpayers.

State credits may be reserved by the director to an application only if the maximum amount of federal credits (determined by the use of the full applicable percentage as defined in the IRC, regardless of the amount requested by the applicant) which could be claimed for any development is determined by the director not to be sufficient for the financial feasibility of the development and its viability as a qualified low-income housing development throughout the credit period under the IRC. The amount of state credits which may be reserved shall be equal to the lesser of (i) the amount requested by the applicant or (ii) the amount which is necessary for such financial feasibility and viability as so determined by the director. Such determination shall be made by the director in the same manner and based upon the same factors and assumptions as the determination described in § 6 with respect to reservation of federal credits. In addition, the director may establish assumptions as to the amount of additional net syndication proceeds to be generated by reason of the state credits (based upon such percentage of the state credit dollar amount used for development costs, other than costs of intermediaries, as the director shall determine to be reasonable for the proposed development). The amount of state credits which may be so reserved shall be based upon a percentage of the federal credits as the director shall determine to produce such amount of state credits.

The director may divide the amount of state credits into pools and may further divide those pools into subpools based upon the factors set forth in § 6 with respect to the federal credits; however, the state credits need not be so divided in the same manner or proportions as the federal credits. Applications for state credits shall be assigned points and ranked at the same time or times and in the same manner as described in § 6. The director shall reserve state credits to applications in descending order of ranking within each pool or subpool, if applicable, until either all state credits therein are reserved or all applications therein eligible for state credits hereunder have received reservations for state credits. Any amounts in any pools or subpools not reserved to applications shall be reallocated at the time or times and in the same manner as the federal credits, among the pools or subpools in which applications eligible for state credits hereunder shall have not received reservations of state credits in the full amount permissible under these procedures. Such allocation shall be made pro rata based on the amount originally allocated to each such pool or subpool with such excess applications divided by the total amount originally allocated to all such pools or subpools with such excess applications. Such reallocations shall continue to be made until either all of the state credits are reserved or all applications for state credits have received reservations.

Section 6 hereof contains certain provisions relating to requirements for good faith deposits and contractual agreements, allocation of state credits without any prior reservation thereof, deadlines for determining the ability of the applicant to qualify for state credits, and reduction and termination of state credits. Such provisions shall be applicable to all applicants for state credits, notwithstanding the fact that the developments or buildings may be financed by certain tax-exempt bonds in an amount so as not to require an allocation of federal credits hereunder. In the event that any reservation of state credits is reduced or terminated, the director may reserve or allocate, as applicable, such state credits to other eligible applicants in such manner as he shall determine consistent with the requirements of the state code.

§ 8. Allocation of federal credits.

At such time as one or more of an applicant's buildings or an applicant's development which has received a reservation of federal credits is (i) placed in service or satisfies the requirements of § 42(h)(1)(E) of the IRC and (ii) meets all of the preallocation requirements of these procedures, the binding commitment and any other applicable contractual agreements between the applicant and the department, the applicant shall so advise the department, shall request the allocation of all of the federal credits so reserved or such portion thereof to which the applicant's buildings or development is then entitled under the IRC, these procedures, the binding commitment and the aforementioned contractual agreements, if any, and shall submit such application, certifications, legal and accounting opinions, evidence as to costs, a breakdown of sources and uses of funds, pro forma financial statements setting forth anticipated cash flows, and other documentation as the director shall require in order to determine that the applicant's buildings or development is entitled to such federal credits as described above. The applicant shall certify to the department the full extent of all federal, state and local subsidies which apply (or which the applicant expects to apply) with respect to the buildings or the development.

As of the date of allocation of federal credits to any building or development and as of the date such building or such development is placed in service, the director shall determine the amount of federal credits to be necessary for the financial feasibility of the development and its viability as a qualified low-income housing development throughout the credit period under the IRC. In making such determinations, the director shall consider the sources and uses of the funds (including, without limitation, any funds to be derived from the state credits), 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 department to be generated with respect to the development and the percentage of the federal 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, in his sole discretion, to be reasonable. The

director shall review the applicant's projected rental income, operating expenses and debt service for the credit period. The director may establish such criteria and assumptions as he shall then deem reasonable (or he may apply the criteria and assumptions he established pursuant to § 6) for the purpose of making such determinations, including, without limitation, criteria as to the reasonableness of fees and profits and assumptions as to the amount of net syndication proceeds to be received (based upon such percentage of the federal credit dollar amount used for development costs, other than the costs of intermediaries, as the director shall determine to be reasonable for the proposed development), increases in the market value of the development, and increases in operating expenses, rental income and, in the case of applications without firm financing commitments (as defined in § 6 hereinabove) at fixed interest rates, debt service on the proposed mortgage loan. The amount of federal credits allocated to the applicant shall in no event exceed such amount as so determined by the director by more than a de minimis amount of not more than $100.

In the case of any buildings or development to be financed by certain tax-exempt bonds in such amount so as not to require under the IRC an allocation of federal credits hereunder, the director shall, upon timely request by the owner thereof, make the foregoing determination as of the date the buildings or the development is placed in service, and for the purpose of such determination, the owner of the buildings or development shall submit to the department such of the above described information and documents and such other information and documents as the director may require. The director shall also determine, in accordance with the IRC and upon timely request by the owner thereof, for such buildings or development (and, in addition, for any buildings or development to be financed by certain tax-exempt bonds of an issuer other than the department in such amount so as not to require under the IRC an allocation of federal credits hereunder) whether such buildings or development satisfies the requirements for allocation of federal credits hereunder.

Prior to allocating the federal credits to an applicant, the director shall require the applicant to execute, deliver and record among the land records of the appropriate jurisdiction or jurisdictions an extended low-income housing commitment in accordance with the requirements of the IRC. Such commitment shall require that the applicable fraction (as defined in the IRC) for the buildings for each taxable year in the extended use period (as defined in the IRC) will not be less than the applicable fraction specified in such commitment and which prohibits both (i) the eviction or the termination of tenancy (other than for good cause) of an existing tenant of a low-income unit and (ii) any increase in the gross rent with respect to such unit not otherwise permitted under the IRC. The amount of federal credits allocated to any building shall not exceed the amount necessary to support such applicable fraction, including any increase thereto pursuant to § 42(f)(3) of the IRC reflected in an amendment to such commitment. The commitment shall provide that the extended use period will end on the day 15 years after the close of the compliance period (as defined in the IRC) or on the last day of any longer period of time specified in the application during which low-income housing units in the development will be occupied by tenants with incomes not in excess of the applicable income limitations; provided, however, that the extended use period for any building shall be subject to termination, in accordance with the IRC, (i) on the date the building is acquired by foreclosure or instrument in lieu thereof unless a determination is made pursuant to the IRC that such acquisition is part of an agreement with the current owner thereof, a purpose of which is to terminate such period or (ii) the last day of the one-year period following the written request by the applicant as specified in the IRC (such period in no event beginning earlier than the end of the fourteenth year of the compliance period) if the department is unable to present during such one-year period a qualified contract (as defined in the IRC) for the acquisition of the building by any person who will continue to operate the low-income portion thereof as a qualified low-income building. In addition, such termination shall not be construed to permit, prior to close of the three-year period following such termination, the eviction or termination of tenancy of any existing tenant of any low-income housing unit other than for good cause or any increase in the gross rents over the maximum rent levels then permitted by the IRC with respect to such low-income housing units. Such commitment shall also contain such other terms and conditions as the director may deem necessary or appropriate to assure that the applicant and the development conform to the representations, commitments and information in the application and comply with the requirements of the IRC (and, in the case of an allocation of state credits, the state code) and these procedures. Such commitment shall be a restrictive covenant on the buildings binding on all successors to the applicant and shall be enforceable in any state court of competent jurisdiction by individuals (whether prospective, present or former occupants) who meet the applicable income limitations under the IRC. Such commitment shall also be required with respect to any development financed by certain tax-exempt bonds in an amount so as not to require an allocation of federal credits hereunder and the form thereof shall be made available to owners of such developments upon their timely request therefor.

In accordance with the IRC, the director may, for any calendar year during the project period (as defined in the IRC), allocate federal credits to a development, as a whole, which contains more than one building. Such an allocation shall apply only to buildings placed in service during or prior to the end of the second calendar year after the calendar year in which such allocation is made, and the portion of such allocation allocated to any building shall be specified not later than the close of the calendar year in which such building is placed in service. Any such allocation shall be subject to satisfaction of all requirements under the IRC.

If the director determines that the buildings or development is so entitled to the federal credits, he shall allocate the federal credits (or such portion thereof to which he deems the buildings or the development to be entitled) to the applicant's qualified low income buildings or to the applicant's development in accordance with the requirements of the IRC. If the director shall determine that the applicant's buildings or development is not so entitled to the federal credits, he shall not allocate the federal credits and shall so notify the applicant within a reasonable time after such determination is made. In the event that any such applicant shall not request an allocation of all of its reserved federal credits or whose buildings or development shall be deemed by the director not to be entitled to any or all of its reserved federal credits, the director may reserve or allocate, as applicable, such unallocated federal credits to the buildings or developments of other qualified applicants at such time or times and in such manner as he shall determine consistent with the requirements of the IRC and these procedures.

The director may prescribe (i) such deadlines for submissions of requests for allocations of federal credits (and, if applicable, state credits) for any calendar year as he deems necessary or desirable to allow sufficient processing time for the department to make such allocations within such calendar year and (ii) such deadlines for satisfaction of all preallocation requirements of the IRC (and, in the case of state credits, the state code), the binding commitment, any contractual agreements between the department and the applicant and these procedures as he deems necessary or desirable to allow the department sufficient time to allocate to other eligible applicants any federal credits for which the applicants fail to satisfy such requirements.

The director may make the allocation of federal credits subject to such terms as he may deem necessary or appropriate to assure that the applicant and the development comply with the requirements of the IRC.

The director may also (to the extent not already required under § 6 hereof) require that all applicants make such good faith deposits or execute such contractual agreements with the department as the director may require with respect to the federal credits (and, if applicable, state credits), (i) to ensure that the buildings or development are completed in accordance with the binding commitment, including all of the representations made in the application for which points were assigned pursuant to § 6 hereof and (ii) only in the case of any buildings or development which are to receive an allocation of federal credits hereunder and which are to be placed in service in any future year, to assure that the buildings or the development will be placed in service as a qualified low-income housing project (as defined in the IRC) in accordance with the IRC and that the applicant will otherwise comply with all of the requirements under the IRC.

In the event that the director determines that a development for which an allocation of federal credits is made shall not become a qualified low-income housing project (as defined in the IRC) within the time period required by the IRC or the terms of the allocation or any contractual agreements between the applicant and the department, the director may terminate the allocation and rescind the federal credits in accordance with the IRC and, in addition, may draw on any good faith deposit and enforce any of the department's rights and remedies under any contractual agreement. An allocation of federal credits to an applicant may also be cancelled with the mutual consent of such applicant and the director. Upon the termination or cancellation of any federal credits, the director may reserve, allocate or carry over, as applicable, such federal credits in such manner as he shall determine consistent with the requirements of the IRC and these procedures.

§ 9. Allocation of state credits.

Upon the allocation of federal credits to the buildings or development described in an application which received a reservation of state credits under § 7, the director shall allocate state credits to such buildings or development in an amount equal to the amount of federal credits so allocated times such percentage of federal credits as shall have been determined by the director under § 7 but in no event shall such amount of state credits exceed the amount reserved to the application under § 7. If the amount of state credits so allocated to the buildings or development under this § 9 is less than the amount of state credits reserved to the application under § 7, the director may reserve to other applications or allocate to other buildings or developments, as applicable, such unallocated state credits at such time or times and in such manner as he shall determine consistent with the requirements of the state code.

In the case of any buildings or development to be financed by certain tax-exempt bonds in an amount so as not to require under the IRC an allocation of federal credits hereunder, the director shall, prior to the last day of the calendar year in which such building or development is reserved state credits, allocate state credits to the buildings or development in an amount equal to the amount of federal credits to be claimed annually by the applicant times such percentage of federal credits as shall have been determined by the director under § 7 but in no event shall such amount of state credits exceed the amount reserved to the application under § 7.

Prior to any allocation of state credits, the director may require the applicant to confirm the status of the owner or owners as Virginia taxpayers who are eligible for an allocation of state credits under § 7.

The director may make the allocation of state credits subject to such terms as he may deem necessary or appropriate to assure that the applicant and the development conform to the representations, commitments, and information in the application and comply with the

requirements of the IRC, the state code, and these procedures.

The state credits allocated may be claimed for the first five taxable years in which the federal credits shall be claimed. The amount of state credits claimed in each such year shall be such percentage of the federal credits so claimed as shall have been established by the director pursuant to § 7; provided, however, that the amount of state credits which may be claimed by the applicant in the initial taxable year shall be calculated for the entire development on the basis of a twelve-month period during such initial taxable year, notwithstanding that the federal credits may be calculated on the basis of some (but not all) of the buildings in such development or on the basis of a period of less than twelve months or both; provided, further, that in no event shall the amount of state credits claimed in any year exceed the amount allocated under this § 9.

In the event that any federal credits claimed by the applicant for any taxable year in which the applicant also claimed state credits shall be recaptured pursuant to the IRC, the state credits for such taxable year shall be recaptured in an amount equal to the amount of federal credits recaptured for such taxable year times such percentage as shall have been established by the director pursuant to § 7. The applicants receiving state credits shall provide the department with such information as the director may from time to time request regarding any recapture of the federal credits.

On or before such date each year as the director may require, each applicant shall apply to the department to determine the amount of state credits which such applicant may claim for the applicable taxable year. Each such applicant shall submit such documents, certifications and information as the director may require. The department shall certify to the Department of Taxation on forms prepared by the department that the applicant qualified for the state credits in the amount set forth therein and shall provide such certification to the applicant. Such certification is required to be attached to the applicant's state income tax return to be filed with the Department of Taxation.

Section 8 hereof contains certain provisions relating to (i) the establishment of deadlines for submission of requests for allocation of state credits and for satisfaction of requirements of the IRC and state code and (ii) requirements for good faith deposits and contractual agreements. Such provisions shall be applicable to all applicants for state credits, notwithstanding the fact that the developments or buildings may be financed by certain tax-exempt bonds in an amount so as not to require an allocation of federal credits hereunder.

In the event that any allocation of federal credits shall be terminated and rescinded or cancelled pursuant to § 8 (or, in the case of any development or buildings to be financed by certain tax-exempt bonds in an amount so as not to require an allocation of federal credits hereunder, in the event that the development shall not become a qualified low-income housing project as defined in the IRC within the time period required by the IRC or by the terms of the allocation of state credits), the director may also terminate and rescind or cancel the state credits and, if permitted by the state code, may reserve or allocate, as applicable, such state credits to other qualified applicants at such time or times and in such manner as he shall determine consistent with the requirements of the state code.

§ 10. Reservation and allocation of additional federal credits and state credits.

Prior to the initial determination of the "qualified basis" (as defined in the IRC) of the qualified low-income buildings of a development pursuant to the IRC, an applicant to whose buildings federal credits or state credits or both have been reserved may submit an application for a reservation of additional federal credits or state credits or both. Subsequent to such initial determination of the qualified basis, the applicant may submit an application for an additional allocation of federal credits or state credits or both by reason of an increase in qualified basis based on an increase in the number of low-income housing units or in the amount of floor space of the low-income housing units. Any application for an additional allocation of federal credits or state credits or both shall include such information, opinions, certifications and documentation as the director shall require in order to determine that the applicant's buildings or development will be entitled to such additional federal credits or state credits or both under the IRC, the state code and these procedures. The application shall be submitted, reviewed, ranked and selected by the director in accordance with the provisions of §§ 6 and 7 hereof, and any allocation of federal credits or state credits or both shall be made in accordance with §§ 8 and 9 hereof. For the purposes of such review, ranking and selection and the determinations to be made by the director under the procedures as to the financial feasibility of the development and its viability as a qualified low-income development during the credit period, the amount of federal credits or state credits, or both, previously reserved to the application or allocated to the buildings or development (or, in the case of any development or building to be financed by certain tax-exempt bonds in an amount so as not to require an allocation of federal credits hereunder, the amount of federal credit which may be claimed by the applicant) shall be included with the amount of such federal credits or state credits or both so requested.

§ 11. Monitoring for IRS compliance.

All applicants who receive an allocation of federal credits are responsible for complying with § 42 of the IRC.

The federal law requires that the Commonwealth monitor projects receiving federal credits for noncompliance with the provisions of § 42 of the IRC and

notify the [~~IRS~~ Internal Revenue Service] of such noncompliance with which it becomes aware.

[~~Unless additional procedures are required by the Internal Revenue Service, applicants must submit to the department copies of reports satisfying the reporting requirements of syndicators or public lenders such as the department, FmHA or HUD which are involved in the project. For those projects which do not have reporting requirements imposed by a public lender or a syndicator, the department will require the sponsor to file an annual certification of compliance with the department.~~

~~§ 12. Notification to the Internal Revenue Service of noncompliance with IRC.~~

All applicants who receive an allocation of federal credits shall take or cause to be taken all action required of the applicant by the department in order to satisfy the department's monitoring requirements. The department shall set forth such monitoring requirements in writing and shall make copies available to all applicants. The department may amend and revise such requirements from time to time in order to comply with § 42 of the IRC.

Applicants must pay to the department a fee in such amount and at such time as the department, in its sole discretion, shall reasonably require the applicant to pay in order to reimburse the department for the costs of such monitoring.]

In the event that the director shall become aware of noncompliance by any applicant with any of the provisions of § 42 of the IRC, the director shall [; ~~within 90 days,~~] notify the Internal Revenue Service of such noncompliance [within the timeframes established by the Internal Revenue Service] . Such notification shall identify the applicant and the buildings and shall describe the noncompliance.

VIRGINIA HOUSING DEVELOPMENT AUTHORITY

REGISTRAR'S NOTICE: VR 400-02-0011, Rules and Regulations for Allocation of Low-Income Housing Tax Credits, became effective on December 4, 1991, and was published in The Virginia Register on December 30, 1991. By Executive Order No. Forty (91), the Governor has transferred this regulation to the Department of Housing and Community Development. Please refer to that Department's entry in the Final Regulations section of this Register for full text.

Title of Regulation: **VR 400-02-0011. Rules and Regulations for Allocation of Low-Income Housing Tax Credits. (REPEAL)**

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

Effective Date: July 1, 1992.

Summary:

VHDA is repealing its rules and regulations governing the allocation of federal low-income housing tax credits ("Credits") available under § 42 of the Internal Revenue Code (the "IRC").

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (BOARD OF)

REGISTRAR'S NOTICE: This regulation is excluded from Article 2 of the Administrative Process Act in accordance with § 9-6.14:4.1 C 4(a) of the Code of Virginia, which excludes regulations that are necessary to conform to changes in Virginia statutory law where no agency discretion is involved. The Department of Medical Assistance Services will receive, consider and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: **State Plan for Medical Assistance Relating to 1992 Appropriations Act Mandates.**
VR 460-01-56.1. Cost Sharing and Similar Charges.
VR 460-03-3.1100. Amount, Duration and Scope of Services.
VR 460-02-4.1810. Changes Imposed on Categorically Needy for Certain Services.
VR 460-02-4.1830. Charges Imposed on Medically Needy for Certain Services.

Statutory Authority: § 32.1-325 of the Code of Virginia.

Effective Date: July 1, 1992.

Summary:

These amendments concern the modification of recipient copayment policies, the coverage of screening mammograms and the limitations on home health and rehabilitative services.

The sections of the State Plan for Medical Assistance affected by this regulatory action are Attachment 3.1 A & B, Supplement 1 (the Amount, Duration, and Scope of Services) and Attachments 4.18 A & C (Cost Sharing).

Supplement 1 to Attachment 3.1 A & B. Limitations on home health nursing and home health aides:

Currently, the Plan provides up to 32 visits within a 60-day period or a total of 64 visits annually for either nurses or home health aides. Requests for additional nursing services must be authorized by DMAS.

The 1992 changes mandated by the General Assembly require that nursing visits and home health aide visits be limited to 32 visits annually per service. There are no provisions for extended nursing or home health aide services beyond these limitations. Recipients who

are at risk of institutionalization may be eligible for services similar to home health aide services under the personal care waiver. Home health skilled nursing and aide services that are medically necessary may be approved under EPSDT for those recipients under age 21.

Limitations on physical therapy, occupational therapy, and speech-language pathology services:

For the rehabilitative services of physical therapy, occupational therapy, and speech-language therapy, the Plan currently provides up to 24 visits within a 60-day period or a total of 48 visits annually for each ordered service. Requests for additional services must be authorized by DMAS.

The 1992 Appropriations Act limited the coverage of physical therapy, occupational therapy and speech-language services which are provided through home health agencies, rehabilitation agencies, or hospital outpatient departments be limited to 24 visits annually per service. The Act also requires preauthorization by DMAS of all visits in excess of 24 visits per year.

Coverage of screening mammograms.

At present, screening mammograms are not covered.

This regulation provides for the coverage of screening mammograms for asymptomatic women aged 35 and over. The 1992 changes mandated by the General Assembly require that screening mammograms be covered for asymptomatic women according to the guidelines published by the American Cancer Society.

Attachment 4.18 A & C. Modifications on the recipient cost sharing (copay) policy:

Currently, the Plan provides that recipient copays are deducted from payments for certain services. Categorically needy recipients are responsible for copays for prescriptions, clinic visits, and eye examinations. Medically needy recipients are responsible for copays for those services plus inpatient hospital visits, outpatient hospital clinic visits, and physician office visits.

The 1992 changes mandated by the General Assembly require that copays for categorically needy recipients be expanded to be the same as for the medically needy. Also, for purposes of collecting copays, recipients in the group called qualified Medicare beneficiaries are to be considered the same as categorically needy. It also increases some copay amounts and adds copays for home health visits. In accordance with federal regulations, these copays do not apply to institutionalized persons, pregnant women, and children younger than 21 years.

A technical correction is being made to replace the 'x' indicator inadvertently omitted form item 4.18(b)(3)(G) in a previous revision of the Plan page.

VR 460-01-56.1. Cost Sharing and Similar Changes.

CITATION: 447.51 through 58

4.18 (b)(3)(Continued):

(iii) Attachment 4.18-A specifies the:

(A) Service(s) for which a charge(s) is applied;

(B) Nature of the charge imposed on each service;

(C) Amount(s) of and basis for determining the charge(s);

(D) Method used to collect the charge(s);

(E) Basis for determining whether an individual is unable to pay the charge and the means by which such an individual is identified to providers;

(F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b);

(G) Cumulative maximum that applies to all deductible, coinsurance, or copayment charges imposed on a specified time period.

☒ Not applicable. There is no maximum.

CITATION: 1902(a)(52) and 1925(b) of the Act

4.18(b)(4): For families receiving extended benefits during a second 6-month period under § 1925 of the Act, a monthly premium is imposed in accordance with §§ 1925(b)(4) and 1925(b)(5) of the Act.

☐ Yes.

☒ No.

VR 460-03-3.1100. Amount, Duration and Scope of Services.

General.

The provision of the following services cannot be reimbursed except when they are ordered or prescribed, and directed or performed within the scope of the license of a practitioner of the healing arts: laboratory and x-ray services, family planning services, and home health services. Physical therapy services will be reimbursed only when prescribed by a physician.

§ 1. Inpatient hospital services other than those provided in an institution for mental diseases.

A. Medicaid inpatient hospital admissions (lengths-of-stay) are limited to the 75th percentile of PAS (Professional Activity Study of the Commission on Professional and Hospital Activities) diagnostic/procedure limits. For admissions under 15 days that exceed the 75th percentile, the hospital must attach medical justification records to the billing invoice to be considered for additional coverage when medically justified. For all admissions that exceed 14 days up to a maximum of 21 days, the hospital must attach medical justification records to the billing invoice. (See the exception to subsection F of this section.)

B. Medicaid does not pay the medicare (Title XVIII) coinsurance for hospital care after 21 days regardless of the length-of-stay covered by the other insurance. (See exception to subsection F of this section.)

C. Reimbursement for induced abortions is provided in only those cases in which there would be a substantial endangerment to health or life of the mother if the fetus were carried to term.

D. Reimbursement for covered hospital days is limited to one day prior to surgery, unless medically justified. Hospital claims with an admission date more than one day prior to the first surgical date will pend for review by medical staff to determine appropriate medical justification. The hospital must write on or attach the justification to the billing invoice for consideration of reimbursement for additional preoperative days. Medically justified situations are those where appropriate medical care cannot be obtained except in an acute hospital setting thereby warranting hospital admission. Medically unjustified days in such admissions will be denied.

E. Reimbursement will not be provided for weekend (Friday/Saturday) admissions, unless medically justified. Hospital claims with admission dates on Friday or Saturday will be pended for review by medical staff to determine appropriate medical justification for these days. The hospital must write on or attach the justification to the billing invoice for consideration of reimbursement coverage for these days. Medically justified situations are those where appropriate medical care cannot be obtained except in an acute hospital setting thereby warranting hospital admission. Medically unjustified days in such admissions will be denied.

F. Coverage of inpatient hospitalization will be limited to a total of 21 days for all admissions within a fixed period, which would begin with the first day inpatient hospital services are furnished to an eligible recipient and end 60 days from the day of the first admission. There may be multiple admissions during this 60-day period; however, when total days exceed 21, all subsequent claims will be reviewed. Claims which exceed 21 days within 60 days with a different diagnosis and medical justification will be paid. Any claim which has the same or similar diagnosis will be denied.

EXCEPTION: SPECIAL PROVISIONS FOR ELIGIBLE INDIVIDUALS UNDER 21 YEARS OF AGE: Consistent with 42 CFR 441.57, 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 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. Medical documentation justifying admission and the continued length of stay must be attached to or written on the invoice for review by medical staff to determine medical necessity. Medically unjustified days in such admissions will be denied.

G. Repealed.

H. Reimbursement will not be provided for inpatient hospitalization for those surgical and diagnostic procedures listed on the mandatory outpatient surgery list unless the inpatient stay is medically justified or meets one of the exceptions. The requirements for mandatory outpatient surgery do not apply to recipients in the retroactive eligibility period.

I. For the purposes of organ transplantation, all similarly situated individuals will be treated alike. Coverage of transplant services for all eligible persons is limited to transplants for kidneys and corneas. Kidney transplants require preauthorization. Cornea transplants do not require preauthorization. The patient must be considered acceptable for coverage and treatment. The treating facility and transplant staff must be recognized as being capable of providing high quality care in the performance of the requested transplant. The amount of reimbursement for covered kidney transplant services is negotiable with the providers on an individual case basis. Reimbursement for covered cornea transplants is at the allowed Medicaid rate. Standards for coverage of organ transplant services are in Attachment 3.1 E.

J. The department may exempt portions or all of the utilization review documentation requirements of subsections A, D, E, F as it pertains to recipients under age 21, G, or H in writing for specific hospitals from time to time as part of their ongoing hospital utilization review peformance evaluation. These exemptions are based on utilization review performance and review edit criteria which determine an individual hospital's review status as specified in the hospital provider manual. In compliance with federal regulations at 42 CFR 441.200, Subparts E and F, claims for hospitalization in which sterlization, hysterectomy or abortion procedures were performed, shall be subject to medical documentation requirements.

K. Hospitals qualifying for an exemption of all documentation requirements except as described in subsection J above shall be granted "delegated review status" and shall, while the exemption remains in effect, not be required to submit medical documentation to support pended claims on a prepayment hospital utilzation review basis to the extent allowed by federal or state law

or regulation. The following audit conditions apply to delegated review status for hospitals:

1. The department shall conduct periodic on-site post-payment audits of qualifying hospitals using a statistically valid sampling of paid claims for the purpose of reviewing the medical necessity of inpatient stays.

2. The hospital shall make all medical records of which medical reviews will be necessary available upon request, and shall provide an appropriate place for the department's auditors to conduct such review.

3. The qualifying hospital will immediately refund to the department in accordance with § 32.1-325.1 A and B of the Code of Virginia the full amount of any initial overpayment identified during such audit.

4. The hospital may appeal adverse medical necessity and overpayment decisions pursuant to the current administrative process for appeals of post-payment review decisions.

5. The department may, at its option, depending on the utilization review performance determined by an audit based on criteria set forth in the hospital provider manual, remove a hospital from delegated review status and reapply certain or all prepayment utilization review documentation requirements.

§ 2. Outpatient hospital and rural health clinic services.

2a. Outpatient hospital services.

1. Outpatient hospital services means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that:

a. Are furnished to outpatients;

b. Except in the case of nurse-midwife services, as specified in § 440.165, are furnished by or under the direction of a physician or dentist; and

c. Are furnished by an institution that:

(1) Is licensed or formally approved as a hospital by an officially designated authority for state standard-setting; and

(2) Except in the case of medical supervision of nurse-midwife services, as specified in § 440.165, meets the requirements for participation in Medicare.

2. Reimbursement for induced abortions is provided in only those cases in which there would be substantial endangerment of health or life to the mother if the fetus were carried to term.

3. Reimbursement will not be provided for outpatient hospital services for any selected elective surgical procedures that require a second surgical opinion unless a properly executed second surgical opinion form has been obtained from the physician and submitted with the invoice for payment, or is a justified emergency or exemption.

2b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.

The same service limitations apply to rural health clinics as to all other services.

2c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with § 4231 of the State Medicaid Manual (HCFA Pub. 45-4).

The same service limitations apply to FQHCs as to all other services.

§ 3. Other laboratory and x-ray services.

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

§ 4. Skilled nursing facility services, EPSDT and family planning.

4a. 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.

4b. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.

1. Consistent with 42 CFR 441.57, 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.

4c. Family planning services and supplies for individuals of child-bearing age.

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

§ 5. Physician's services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere.

A. Elective surgery as defined by the Program is surgery that is not medically necessary to restore or materially improve a body function.

B. Cosmetic surgical procedures are not covered unless performed for physiological reasons and require Program prior approval.

C. Routine physicals and immunizations are not covered except when the services are provided under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program and when a well-child examination is performed in a private physician's office for a foster child of the local social services department on specific referral from those departments.

D. Psychiatric services are limited to an initial availability of 26 sessions, with one possible extension (subject to the approval of the Psychiatric Review Board) of 26 sessions during the first year of treatment. The availability is further restricted to no more than 26 sessions each succeeding year when approved by the Psychiatric Review Board. Psychiatric services are further restricted to no more than three sessions in any given seven-day period. These limitations also apply to psychotherapy sessions by clinical psychologists licensed by the State Board of Medicine and psychologists clinical licensed by the Board of Psychology.

E. Any procedure considered experimental is not covered.

F. Reimbursement for induced abortions is provided in only those cases in which there would be a substantial endangerment of health or life to the mother if the fetus were carried to term.

G. Physician visits to inpatient hospital patients are limited to a maximum of 21 days per admission within 60 days for the same or similar diagnoses and is further restricted to medically necessary inpatient hospital days as determined by the Program.

EXCEPTION: SPECIAL PROVISIONS FOR ELIGIBLE INDIVIDUALS UNDER 21 YEARS OF AGE: Consistent with 42 CFR 441.57, 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 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. Payments for physician visits for inpatient days determined to be medically unjustified will be adjusted.

H. Psychological testing and psychotherapy by clinical psychologists licensed by the State Board of Medicine and psychologists clinical licensed by the Board of Psychology are covered.

I. Repealed.

J. Reimbursement will not be provided for physician services performed in the inpatient setting for those surgical or diagnostic procedures listed on the mandatory outpatient surgery list unless the service is medically justified or meets one of the exceptions. The requirements of mandatory outpatient surgery do not apply to recipients in a retroactive eligibility period.

K. For the purposes of organ transplantation, all similarly situated individuals will be treated alike. Coverage of transplant services for all eligible persons is limited to transplants for kidneys and corneas. Kidney transplants require preauthorization. Cornea transplants do not require preauthorization. The patient must be considered acceptable for coverage and treatment. The treating facility and transplant staff must be recognized as being capable of providing high quality care in the performance of the requested transplant. The amount of reimbursement for covered kidney transplant services is negotiable with the providers on an individual case basis. Reimbursement for covered cornea transplants is at the allowed Medicaid rate. Standards for coverage of organ transplant services are in Attachment 3.1 E.

§ 6. Medical care by other licensed practitioners within the scope of their practice as defined by state law.

A. Podiatrists' services.

1. Covered podiatry services are defined as reasonable and necessary diagnostic, medical, or surgical treatment of disease, injury, or defects of the human foot. These services must be within the scope of the license of the podiatrists' profession and defined by state law.

2. The following services are not covered: preventive health care, including routine foot care; treatment of structural misalignment not requiring surgery; cutting or removal of corns, warts, or calluses; experimental procedures; acupuncture.

3. The Program may place appropriate limits on a service based on medical necessity or for utilization

control, or both.

B. Optometric services.

1. Diagnostic examination and optometric treatment procedures and services by ophthamologists, optometrists, and opticians, as allowed by the Code of Virginia and by regulations of the Boards of Medicine and Optometry, are covered for all recipients. Routine refractions are limited to once in 24 months except as may be authorized by the agency.

C. Chiropractors' services.

Not provided.

D. Other practitioners' services.

1. Clinical psychologists' services.

a. These limitations apply to psychotherapy sessions by clinical psychologists licensed by the State Board of Medicine and psychologists clinical licensed by the Board of Psychology. Psychiatric services are limited to an initial availability of 26 sessions, with one possible extension of 26 sessions during the first year of treatment. The availability is further restricted to no more than 26 sessions each succeeding year when approved by the Psychiatric Review Board. Psychiatric services are further restricted to no more than three sessions in any given seven-day period.

b. Psychological testing and psychotherapy by clinical psychologists licensed by the State Board of Medicine and psychologists clinical licensed by the Board of Psychology are covered.

§ 7. Home health services.

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

B. Nursing services provided by a home health agency.

1. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.

2. Patients may receive up to 32 visits ~~within a 60-day period without authorization. A patient may receive a maximum of 64 nursing visits annually without authorization. If services beyond these limitations are determined by the physician to be required, then the home health agency shall request authorization from DMAS for additional services~~ *annually . Limits are per recipient, regardless of the number of providers rendering services. Annually shall be defined as July 1 through June 30 for each recipient.*

C. Home health aide services provided by a home health agency.

1. Home health aides must function under the supervision of a professional nurse.

2. Home health aides must meet the certification requirements specified in 42 CFR 484.36.

3. For home health aide services, patients may receive up to 32 visits ~~within a 60-day period without authorization from DMAS. A recipient may receive a maximum of 64 visits annually without authorization. If services beyond these limitations are determined by the physician to be required, then the home health agency shall request authorization from DMAS for additional services~~ *annually . Limits shall be per recipient, regardless of the number of providers rendering services. Annually shall be defined as July 1 through June 30 for each recipient.*

D. Medical supplies, equipment, and appliances suitable for use in the home.

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

2. Medical supplies, equipment, and appliances for all others are limited to home renal dialysis equipment and supplies, respiratory equipment and oxygen, and ostomy supplies, as authorized by the agency.

3. Supplies, equipment, or appliances that are not covered include, but are not limited to, the following:

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

b. Durable medical equipment and supplies for any hospital or nursing facility resident, except ventilators and associated supplies for nursing facility residents that have been approved by DMAS central office.

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

d. Items that are only for the recipient's comfort and convenience or for the convenience of those caring for the recipient (e.g., a hospital bed or mattress because the recipient does not have a

decent bed; wheelchair trays used as a desk surface; mobility items used in addition to primary assistive mobility aide for caregiver's or recipient's convenience (i.e., electric wheelchair plus a manual chair); cleansing wipes.

e. Prosthesis, except for artificial arms, legs, and their supportive devices which must be preauthorized by the DMAS central office (effective July 1, 1989).

f. Items and services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member (for example, over-the-counter drugs; dentifrices; toilet articles; shampoos which do not require a physician's prescription; dental adhesives; electric toothbrushes; cosmetic items, soaps, and lotions which do not require a physician's prescription; sugar and salt substitutes; support stockings; and nonlegend drugs.

g. Orthotics, including braces, splints, and supports.

h. Home or vehicle modifications.

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

j. Equipment that the primary function is vocationally or educationally related (i.e., computers, environmental control devices, speech devices, etc.).

E. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

1. Service covered only as part of a physician's plan of care.

2. Patients may receive up to 24 visits for each rehabilitative therapy service ordered ~~within a 60-day period without authorization. Patients may receive up to 48 visits for each rehabilitative service ordered annually without authorization.~~ *annually. Limits shall apply per recipient regardless of the number of providers rendering services. Annually shall be defined as July 1 through June 30 for each recipient.* If services beyond these limitations are determined by the physician to be required, then the ~~home health agency~~ *provider* shall request *prior* authorization from DMAS for additional services.

§ 8. Private duty nursing services.

Not provided.

§ 9. Clinic services.

A. Reimbursement for induced abortions is provided in only those cases in which there would be a substantial endangerment of health or life to the mother if the fetus was carried to term.

B. Clinic services means preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that:

1. Are provided to outpatients;

2. Are provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients; and

3. Except in the case of nurse-midwife services, as specified in 42 dentist.

§ 10. Dental services.

A. Dental services are limited to recipients under 21 years of age in fulfillment of the treatment requirements under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program and defined as routine diagnostic, preventive, or restorative procedures necessary for oral health provided by or under the direct supervision of a dentist in accordance with the State Dental Practice Act.

B. Initial, periodic, and emergency examinations; required radiography necessary to develop a treatment plan; patient education; dental prophylaxis; fluoride treatments; dental sealants; routine amalgam and composite restorations; crown recementation; pulpotomies; emergency endodontics for temporary relief of pain; pulp capping; sedative fillings; therapeutic apical closure; topical palliative treatment for dental pain; removal of foreign body; simple extractions; root recovery; incision and drainage of abscess; surgical exposure of the tooth to aid eruption; sequestrectomy for osteomyelitis; and oral antral fistula closure are dental services covered without preauthorization by the state agency.

C. All covered dental services not referenced above require preauthorization by the state agency. The following services are also covered through preauthorization: medically necessary full banded orthodontics, for handicapping malocclusions, minor tooth guidance or repositioning appliances, complete and partial dentures, surgical preparation (alveoloplasty) for prosthetics, single permanent crowns, and bridges. The following service is not covered: routine bases under restorations.

D. The state agency may place appropriate limits on a service based on medical necessity, for utilization control, or both. Examples of service limitations are: examinations, prophylaxis, fluoride treatment (once/six months); space maintenance appliances; bitewing x-ray – two films (once/12 months); routine amalgam and composite restorations (once/three years); dentures (once per 5 years); extractions, orthodontics, tooth guidance appliances, permanent crowns, and bridges, endodontics, patient

education and sealants (once).

E. Limited oral surgery procedures, as defined and covered under Title XVIII (Medicare), are covered for all recipients, and also require preauthorization by the state agency.

§ 11. Physical therapy and related services.

Physical therapy and related services shall be defined as physical therapy, occupational therapy, and speech-language pathology services. These services shall be prescribed by a physician and be part of a written plan of care. Any one of these services may be offered as the sole service and shall not be contingent upon the provision of another service. All practitioners and providers of services shall be required to meet state and federal licensing and/or certification requirements.

11a. Physical Therapy.

A. Services for individuals requiring physical therapy are provided only as an element of hospital inpatient or outpatient service, nursing facility service, home health service, services provided by a local school division employing qualified therapists, or when otherwise included as an authorized service by a cost provider who provides rehabilitation services.

B. Effective July 1, 1988, the Program will not provide direct reimbursement to enrolled providers for physical therapy service rendered to patients residing in long term care facilities. Reimbursement for these services is and continues to be included as a component of the nursing homes' operating cost.

C. Physical therapy services meeting all of the following conditions shall be furnished to patients:

1. Physical therapy services shall be directly and specifically related to an active written care plan designed by a physician after any needed consultation with a physical therapist licensed by the Board of Medicine;

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a physical therapist licensed by the Board of Medicine, or a physical therapy assistant who is licensed by the Board of Medicine and is under the direct supervision of a physical therapist licensed by the Board of Medicine. When physical therapy services are provided by a qualified physical therapy assistant, such services shall be provided under the supervision of a qualified physical therapist who makes an onsite supervisory visit at least once every 30 days. This visit shall not be reimbursable.

3. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services shall be reasonable.

11b. Occupational therapy.

A. Services for individuals requiring occupational therapy are provided only as an element of hospital inpatient or outpatient service, nursing facility service, home health service, services provided by a local school division employing qualified therapists, or when otherwise included as an authorized service by a cost provider who provides rehabilitation services.

B. Effective September 1, 1990, Virginia Medicaid will not make direct reimbursement to providers for occupational therapy services for Medicaid recipients residing in long-term care facilities. Reimbursement for these services is and continues to be included as a component of the nursing facilities' operating cost.

C. Occupational therapy services shall be those services furnished a patient which meet all of the following conditions:

1. Occupational therapy services shall be directly and specifically related to an active written care plan designed by a physician after any needed consultation with an occupational therapist registered and certified by the American Occupational Therapy Certification Board.

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by an occupational therapist registered and certified by the American Occupational Therapy Certification Board, a graduate of a program approved by the Council on Medical Education of the American Medical Association and engaged in the supplemental clinical experience required before registration by the American Occupational Therapy Association when under the supervision of an occupational therapist defined above, or an occupational therapy assistant who is certified by the American Occupational Therapy Certification Board under the direct supervision of an occupational therapist as defined above. When occupational therapy services are provided by a qualified occupational therapy assistant or a graduate engaged in supplemental clinical experience required before registration, such services shall be provided under the supervision of a qualified occupational therapist who makes an onsite supervisory visit at least once every 30 days. This visit shall not be reimbursable.

3. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services shall be reasonable.

11c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist; see Page 1, General and Page 12, Physical Therapy and Related Services.)

A. These services are provided by or under the supervision of a speech pathologist or an audiologist only as an element of hospital inpatient or outpatient service, nursing facility service, home health service, services provided by a local school division employing qualified therapists, or when otherwise included as an authorized service by a cost provider who provides rehabilitation services.

B. Effective September 1, 1990, Virginia Medicaid will not make direct reimbursement to providers for speech-language pathology services for Medicaid recipients residing in long-term care facilities. Reimbursement for these services is and continues to be included as a component of the nursing facilities' operating cost.

C. Speech-language pathology services shall be those services furnished a patient which meet all of the following conditions:

1. The services shall be directly and specifically related to an active written treatment plan designed by a physician after any needed consultation with a speech-language pathologist licensed by the Board of Audiology and Speech Pathology, or, if exempted from licensure by statute, meeting the requirements in 42 CFR 440.110(c);

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by or under the direction of a speech-language pathologist who meets the qualifications in number 1. The program shall meet the requirements of 42 CFR 405.1719(c). At least one qualified speech-language pathologist must be present at all times when speech-language pathology services are rendered; and

3. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services shall be reasonable.

11d. Authorization for services.

A. Physical therapy, occupational therapy, and speech-language pathology services provided in outpatient settings of acute and rehabilitation hospitals, rehabilitation agencies, or home health agencies shall include authorization for up to 24 visits by each ordered rehabilitative service within a 60-day period. A recipient may receive a maximum of 48 visits annually without authorization. The provider shall maintain documentation to justify the need for services.

B. The provider shall request from DMAS authorization for treatments deemed necessary by a physician beyond the number authorized. This request must be signed and dated by a physician. Authorization for extended services shall be based on individual need. Payment shall not be made for additional service unless the extended provision of services has been authorized by DMAS.

11e. Documentation requirements.

A. Documentation of physical therapy, occupational therapy, and speech-language pathology services provided by a hospital-based outpatient setting, home health agency, a school division, or a rehabilitation agency shall, at a minimum:

1. Describe the clinical signs and symptoms of the patient's condition;

2. Include an accurate and complete chronological picture of the patient's clinical course and treatments;

3. Document that a plan of care specifically designed for the patient has been developed based upon a comprehensive assessment of the patient's needs;

4. Include a copy of the physician's orders and plan of care;

5. Include all treatment rendered to the patient in accordance with the plan with specific attention to frequency, duration, modality, response, and identify who provided care (include full name and title);

6. Describe changes in each patient's condition and response to the rehabilitative treatment plan;

7. (Except for school divisions) describe a discharge plan which includes the anticipated improvements in functional levels, the time frames necessary to meet these goals, and the patient's discharge destination; and

8. In school divisions, include an individualized education program (IEP) which describes the anticipated improvements in functional level in each school year and the time frames necessary to meet these goals.

B. Services not specifically documented in the patient's medical record as having been rendered shall be deemed not to have been rendered and no coverage shall be provided.

11f. Service limitations. The following general conditions shall apply to reimbursable physical therapy, occupational therapy, and speech-language pathology:

A. Patient must be under the care of a physician who is legally authorized to practice and who is acting within the scope of his license.

B. Services shall be furnished under a written plan of treatment and must be established and periodically reviewed by a physician. The requested services or items must be necessary to carry out the plan of treatment and must be related to the patient's condition.

C. A physician recertification shall be required periodically, must be signed and dated by the physician who reviews the plan of treatment, and may be obtained when the plan of treatment is reviewed. The physician recertification statement must indicate the continuing need for services and should estimate how long rehabilitative services will be needed.

D. The physician orders for therapy services shall include the specific procedures and modalities to be used, identify the specific discipline to carry out the plan of care, and indicate the frequency and duration for services.

E. Utilization review shall be performed to determine if services are appropriately provided and to ensure that the services provided to Medicaid recipients are medically necessary and appropriate. Services not specifically documented in the patient's medical record as having been rendered shall be deemed not to have been rendered and no coverage shall be provided.

F. Physical therapy, occupational therapy and speech-language services are to be terminated regardless of the approved length of stay when further progress toward the established rehabilitation goal is unlikely or when the services can be provided by someone other than the skilled rehabilitation professional.

§ 12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

12a. Prescribed drugs.

1. Nonlegend drugs, except insulin, syringes, needles, diabetic test strips for clients under 21 years of age, and family planning supplies are not covered by Medicaid. This limitation does not apply to Medicaid recipients who are in skilled and intermediate care facilities.

2. Legend drugs, with the exception of anorexiant drugs prescribed for weight loss and transdermal drug delivery systems, are covered. Coverage of anorexiants for other than weight loss requires preauthorization.

3. The Program will not provide reimbursement for drugs determined by the Food and Drug Administration (FDA) to lack substantial evidence of effectiveness.

4. Notwithstanding the provisions of § 32.1-87 of the Code of Virginia, prescriptions for Medicaid recipients for specific multiple source drugs shall be filled with generic drug products listed in the Virginia Voluntary Formulary unless the physician or other practitioners so licensed and certified to prescribe drugs certifies in his own handwriting "brand necessary" for the prescription to be dispensed as written.

5. New drugs, except for Treatment Investigational New Drugs (Treatment IND), are not covered until approved by the board, unless a physician obtains prior approval. The new drugs listed in Supplement 1 to the New Drug Review Program Regulations (VR 460-05-2000.1000) are not covered.

12b. Dentures.

Provided only as a result of EPSDT and subject to medical necessity and preauthorization requirements specified under Dental Services.

12c. Prosthetic devices.

A. Prosthetics services shall mean the replacement of missing arms and legs. Nothing in this regulation shall be construed to refer to orthotic services or devices.

B. Prosthetic devices (artificial arms and legs, and their necessary supportive attachments) are provided when prescribed by a physician or other licensed practitioner of the healing arts within the scope of their professional licenses as defined by state law. This service, when provided by an authorized vendor, must be medically necessary, and preauthorized for the minimum applicable component necessary for the activities of daily living.

12d. Eyeglasses.

Eyeglasses shall be reimbursed for all recipients younger than 21 years of age according to medical necessity when provided by practitioners as licensed under the Code of Virginia.

§ 13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13a. Diagnostic services.

Not provided.

13b. Screening services.

~~Not provided.~~ *Screening mammograms for the female recipient population aged 35 and over shall be covered, consistent with the guidelines published by the American Cancer Society.*

13c. Preventive services.

Not provided.

13d. Rehabilitative services.

A. Intensive physical rehabilitation:

1. Medicaid covers intensive inpatient rehabilitation services as defined in subdivision A 4 in facilities certified as rehabilitation hospitals or rehabilitation units in acute care hospitals which have been certified

by the Department of Health to meet the requirements to be excluded from the Medicare Prospective Payment System.

2. Medicaid covers intensive outpatient physical rehabilitation services as defined in subdivision A 4 in facilities which are certified as Comprehensive Outpatient Rehabilitation Facilities (CORFs).

3. These facilities are excluded from the 21-day limit otherwise applicable to inpatient hospital services. Cost reimbursement principles are defined in Attachment 4.19-A.

4. An intensive rehabilitation program provides intensive skilled rehabilitation nursing, physical therapy, occupational therapy, and, if needed, speech therapy, cognitive rehabilitation, prosthetic-orthotic services, psychology, social work, and therapeutic recreation. The nursing staff must support the other disciplines in carrying out the activities of daily living, utilizing correctly the training received in therapy and furnishing other needed nursing services. The day-to-day activities must be carried out under the continuing direct supervision of a physician with special training or experience in the field of rehabilitation.

5. Nothing in this regulation is intended to preclude DMAS from negotiating individual contracts with in-state intensive physical rehabilitation facilities for those individuals with special intensive rehabilitation needs.

§ 14. Services for individuals age 65 or older in institutions for mental diseases.

14a. Inpatient hospital services.

Provided, no limitations.

14b. Skilled nursing facility services.

Provided, no limitations.

14c. Intermediate care facility.

Provided, no limitations.

§ 15. Intermediate care services and intermediate care services for institutions for mental disease and mental retardation.

15a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with § 1902 (a)(31)(A) of the Act, to be in need of such care.

Provided, no limitations.

15b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

Provided, no limitations.

§ 16. Inpatient psychiatric facility services for individuals under 22 years of age.

Not provided.

§ 17. Nurse-midwife services.

Covered services for the nurse midwife are defined as those services allowed under the licensure requirements of the state statute and as specified in the Code of Federal Regulations, i.e., maternity cycle.

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

A. Covered hospice services shall be defined as those services allowed under the provisions of Medicare law and regulations as they relate to hospice benefits and as specified in the Code of Federal Regulations, Title 42, Part 418.

B. Categories of care.

As described for Medicare and applicable to Medicaid, hospice services shall entail the following four categories of daily care:

1. Routine home care is at-home care that is not continuous.

2. Continuous home care consists of at-home care that is predominantly nursing care and is provided as short-term crisis care. A registered or licensed practical nurse must provide care for more than half of the period of the care. Home health aide or homemaker services may be provided in addition to nursing care. A minimum of 8 hours of care per day must be provided to qualify as continuous home care.

3. Inpatient respite care is short-term inpatient care provided in an approved facility (freestanding hospice, hospital, or nursing facility) to relieve the primary caregiver(s) providing at-home care for the recipient. Respite care is limited to not more than 5 consecutive days.

4. General inpatient care may be provided in an approved freestanding hospice, hospital, or nursing facility. This care is usually for pain control or acute or chronic symptom management which cannot be successfully treated in another setting.

C. Covered services.

1. As required under Medicare and applicable to Medicaid, the hospice itself must provide all or

substantially all of the "core" services applicable for the terminal illness which are nursing care, physician services, social work, and counseling (bereavement, dietary, and spiritual).

2. Other services applicable for the terminal illness that must be available but are not considered "core" services are drugs and biologicals, home health aide and homemaker services, inpatient care, medical supplies, and occupational and physical therapies and speech-language pathology services.

3. These other services may be arranged, such as by contractual agreement, or provided directly by the hospice.

4. To be covered, a certification that the individual is terminally ill must have been completed by the physician and hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions. The individual must elect hospice care and a plan of care must be established before services are provided. To be covered, services must be consistent with the plan of care. Services not specifically documented in the patient's medical record as having been rendered will be deemed not to have been rendered and no coverage will be provided.

5. All services must be performed by appropriately qualified personnel, but it is the nature of the service, rather than the qualification of the person who provides it, that determines the coverage category of the service. The following services are covered hospice services:

a. Nursing care. Nursing care must be provided by a registered nurse or by a licensed practical nurse under the supervision of a graduate of an approved school of professional nursing and who is licensed as a registered nurse.

b. Medical social services. Medical social services must be provided by a social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education, and who is working under the direction of a physician.

c. Physician services. Physician services must be performed by a professional who is licensed to practice, who is acting within the scope of his or her license, and who is a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor. The hospice medical director or the physician member of the interdisciplinary team must be a licensed doctor of medicine or osteopathy.

d. Counseling services. Counseling services must be provided to the terminally ill individual and the family members or other persons caring for the individual at home. Bereavement counseling consists of counseling services provided to the individual's family up to one year after the individual's death. Bereavement counseling is a required hospice service, but it is not reimbursable.

e. Short-term inpatient care. Short-term inpatient care may be provided in a participating hospice inpatient unit, or a participating hospital or nursing facility. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management which cannot be provided in other settings. Inpatient care may also be furnished to provide respite for the individual's family or other persons caring for the individual at home.

f. Durable medical equipment and supplies. Durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness is covered. Medical supplies include those that are part of the written plan of care.

g. Drugs and biologicals. Only drugs used which are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered.

h. Home health aide and homemaker services. Home health aides providing services to hospice recipients must meet the qualifications specified for home health aides by 42 CFR 484.36. Home health aides may provide personal care services. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient. Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment and services to enable the individual to carry out the plan of care. Home health aide and homemaker services must be provided under the general supervision of a registered nurse.

i. Rehabilitation services. Rehabilitation services include physical and occupational therapies and speech-language pathology services that are used for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

D. Eligible groups.

To be eligible for hospice coverage under Medicare or Medicaid, the recipient must have a life expectancy of six months or less, have knowledge of the illness and life expectancy, and elect to receive hospice services rather

than active treatment for the illness. Both the attending physician and the hospice medical director must certify the life expectancy. The hospice must obtain the certification that an individual is terminally ill in accordance with the following procedures:

1. For the first 90-day period of hospice coverage, the hospice must obtain, within two calendar days after the period begins, a written certification statement signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and the individual's attending physician if the individual has an attending physician. For the initial 90-day period, if the hospice cannot obtain written certifications within two calendar days, it must obtain oral certifications within two calendar days, and written certifications no later than eight calendar days after the period begins.

2. For any subsequent 90-day or 30-day period or a subsequent extension period during the individual's lifetime, the hospice must obtain, no later than two calendar days after the beginning of that period, a written certification statement prepared by the medical director of the hospice or the physician member of the hospice's interdisciplinary group. The certification must include the statement that the individual's medical prognosis is that his or her life expectancy is six months or less and the signature(s) of the physician(s). The hospice must maintain the certification statements.

§ 19. Case management services for high-risk pregnant women and children up to age 1, as defined in Supplement 2 to Attachment 3.1-A in accordance with § 1915(g)(1) of the Act.

Provided, with limitations. See Supplement 2 for detail.

§ 20. Extended services to pregnant women.

20a. Pregnancy-related and postpartum services for 60 days after the pregnancy ends.

The same limitations on all covered services apply to this group as to all other recipient groups.

20b. Services for any other medical conditions that may complicate pregnancy.

The same limitations on all covered services apply to this group as to all other recipient g oups.

§ 21. Any other medical care and any other type of remedial care recognized under state law, specified by the Secretary of Health and Human Services.

21a. Transportation.

Nonemergency transportation is administered by local health department jurisdictions in accordance with reimbursement procedures established by the Program.

21b. Services of Christian Science nurses.

Not provided.

21c. Care and services provided in Christian Science sanitoria.

Provided, no limitations.

21d. Skilled nursing facility services for patients under 21 years of age.

Provided, no limitations.

21e. Emergency hospital services.

Provided, no limitations.

21f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

Not provided.

Emergency Services for Aliens (17.e)

No payment shall be made for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law unless such services are necessary for the treatment of an emergency medical condition of the alien.

Emergency services are defined as:

Emergency treatment of accidental injury or medical condition (including emergency labor and delivery) manifested by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical/surgical attention could reasonably be expected to result in:

1. Placing the patient's health in serious jeopardy;

2. Serious impairment of bodily functions; or

3. Serious dysfunction of any bodily organ or part.

Medicaid eligibility and reimbursement is conditional upon review of necessary documentation supporting the need for emergency services. Services and inpatient lengths of stay cannot exceed the limits established for other Medicaid recipients.

Claims for conditions which do not meet emergency critieria for treatment in an emergency room or for acute care hospital admissions for intensity of service or severity of illness will be denied reimbursement by the Department

of Medical Assistance Services.

VR 460-02-4.1810. Charges Imposed on Categorically Needy for Certain Services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: VIRGINIA

A. The following charges are imposed on the categorically needy *and qualified Medicare beneficiaries* for services other than those provided under § 1905(a)(1) through (5) and (7) of the Act.

Service	Type Charge Deduct	Coins	Copay	Amount and Basis for Determination
Inpatient Hospital	*$100*	*-0-*	*-0-*	*State's average daily payment of $594 is used as basis.*
Outpatient Hospital Clinic	*-0-*	*-0-*	*$3.00*	*State's average payment of $136 is used as basis.*
Clinic Visit	-0-	-0-	$1.00	State's average payment of $29 is used as basis.
Physician Office Visit	*-0-*	*-0-*	*$1.00*	*State's average payment of $23 is used as basis.*
Eye examination	-0-	-0-	$1.00	State's average payment of $30 is used as basis.
~~Pharmacy services~~	~~-0-~~	~~$ .50~~		~~Program payment is $10.00 or less.~~
	~~-0-~~	~~-0-~~	~~$1.00~~	~~Program payment is $10.01 or more.~~
Prescriptions	*-0-*	*-0-*	*$1.00*	*State's average per script of $18 is used as payment basis.*
Home Health Visit	*-0-*	*-0-*	*$3.00*	*State's average payment of $56 is used as basis.*
Other Physician Service	*-0-*	*-0-*	*$3.00*	*State's average payment of $56 is used as basis.*

B. The method used to collect cost sharing charges for categorically needy individuals:

☒ Providers are responsible for collecting the cost sharing charges from individuals.

☐ The agency reimburses providers the full Medicaid rate for a services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

Providers will, based on information available to them, make a determination of the recipient's ability to pay the copayment. In the absence of knowledge or indications to the contrary, providers may accept the recipient's assertion that he/she is unable to pay the required copayment.

Recipients have been notified that inability to meet a copayment at a particular time does not relieve them of that responsibility.

D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

The application and exclusion of cost sharing is administered through the program's MMIS. Documentation of the certified computer system delineates, for each type of provider invoice used, protected eligible groups, protected services and applicable eligible groups and services.

Providers have been informed about: copay exclusions; applicable services and amounts; prohibition of service denial if recipient is unable to meet cost-sharing charges.

E. Cumulative maximums on charges:

☒ State policy does not provide for cumulative maximums.

☐ Cumulative maximums have been established as described below:

VR 460-02-4.1830. Charges Imposed on Medically Needy for Certain Services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: VIRGINIA

A. The following charges are imposed on the medically needy for services:

Service	Type Charge Deduct	Coins	Copay	Amount and Basis for Determination
Inpatient hospital	~~$30.00~~ *$100.00*	-0-	-0-	State's average *daily* payment of ~~$1,903~~ *$594* is used as basis.
Out-patient hospital clinic	-0-	-0-	~~$2.00~~ *$3.00*	State's average payment of ~~$52~~ *$136* is used as basis.
Clinic visit	-0-	-0-	$1.00	State's average payment of $29 is used as basis.
Physician office visit	-0-	-0-	$1.00	State's average payment of ~~$20~~ *$23* is used as basis.
Eye examination	-0-	-0-	$1.00	State's payment of $30.00 is used as basis.
~~Prescription~~	~~-0-~~	~~-0-~~	~~$ .50~~	~~Program payment is $10.00 or less~~
	~~-0-~~	~~-0-~~	~~$1.00~~	~~Program payment is $10.01 or more.~~
Prescriptions	*-0-*	*-0-*	*$1.00*	*State's average per script of $18 is used as basis.*
Home Health Visit	*-0-*	*-0-*	*$3.00*	*State's average payment of $56 is used as basis.*

Other Physician Service	*-0-*	*-0-*	*$3.00*	*State's average payment of $56 is used as basis.*

B. The method used to collect cost sharing charges for medically needy individuals:

☒ Providers are responsible for collecting the cost sharing charges from individuals.

☐ The agency reimburses providers the full Medicaid rate-

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

Providers will, based on information available to them, make a determination of the recipient's ability to pay the copayment. In the absence of knowledge or indications to the contrary, providers may accept the recipient's assertion that he/she is unable to pay the required copayment.

Recipients have been notified that inability to meet a copayment at a particular time does not relieve them of that responsibility.

D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

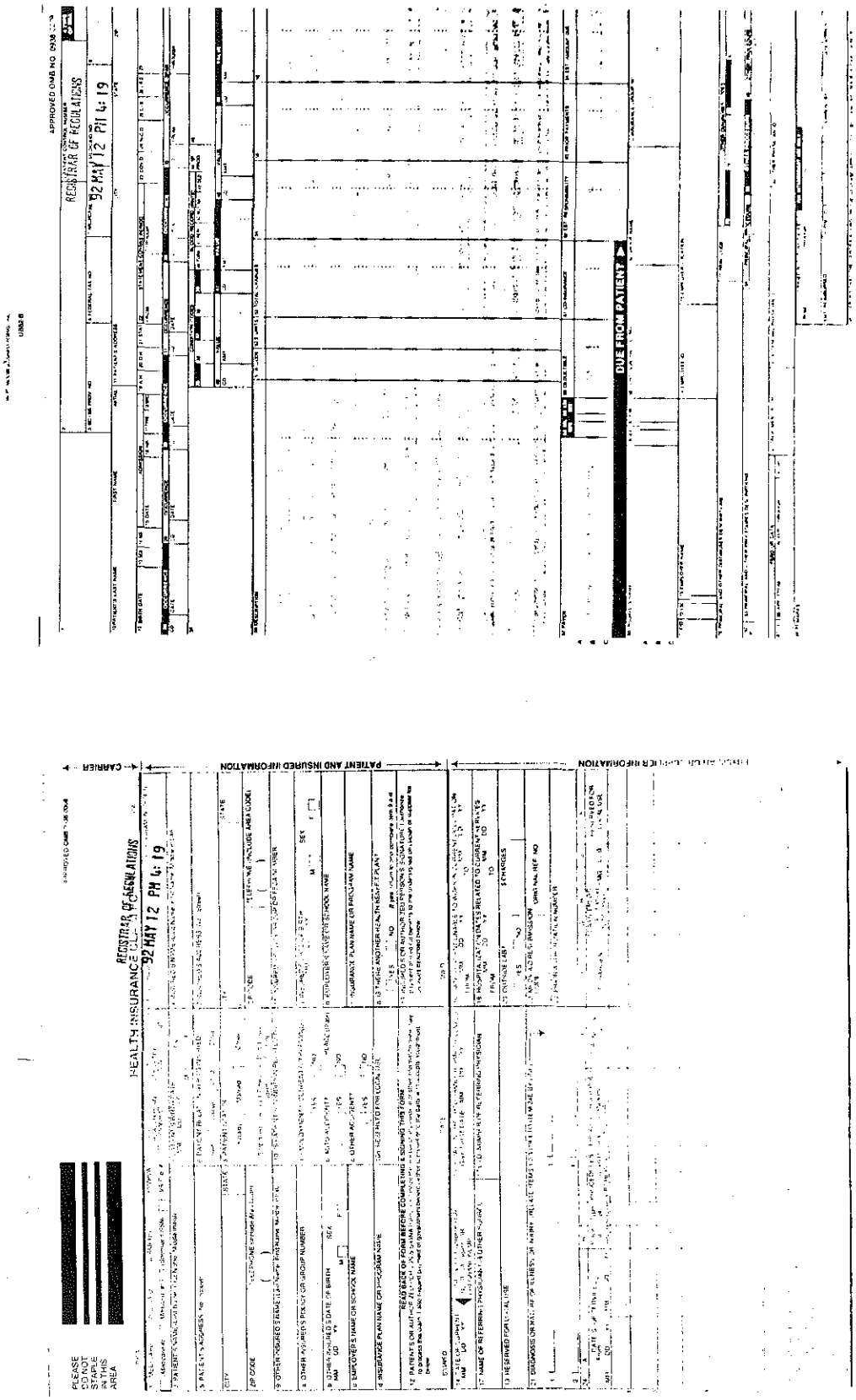
The application and exclusion of cost sharing is administered through the Program's MMIS. Documentation of the certified computer system delineates, for each type of provider invoice used, protected eligible groups, protected services and applicable eligible groups and services.

Providers have been informed about: copay exclusions; applicable services and amounts; prohibition of service denial if recipient is unable to meet cost sharing changes.

E. Cumulative maximums on charges:

☒ State policy does not provide for cumulative maximums.

☐ Cumulative maximums have been established as described below:

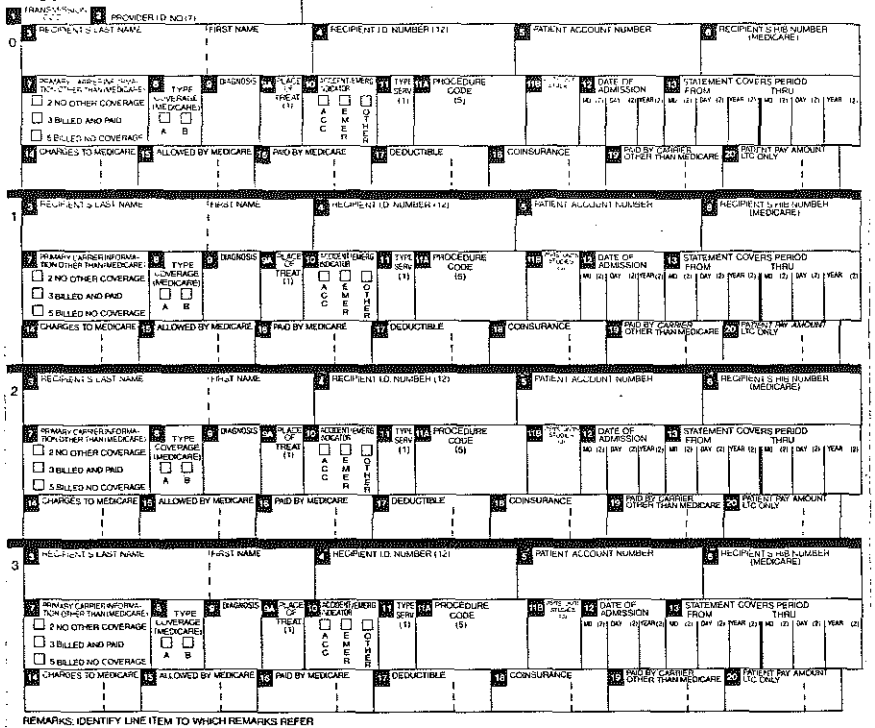

REGISTRAR OF REGULATIONS
92 MAY 12 PM 4:19
HEALTH INSURANCE CLAIM FORM
PATIENT AND INSURED INFORMATION
DUE FROM PATIENT
PLEASE DO NOT STAPLE IN THIS AREA

TITLE XVIII (MEDICARE) DEDUCTIBLE AND COINSURANCE INVOICE

VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

091



REMARKS: IDENTIFY LINE ITEM TO WHICH REMARKS REFER

THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.

SIGNATURE DATE

ORIGINAL COPY

DMAS - 30 R 1/91

INSTRUCTIONS FOR COMPLETING TITLE XVIII (MEDICARE) DEDUCTIBLE AND COINSURANCE INVOICE
DMAS - 30

PURPOSE: To provide a means for providers to submit the applicable Medicare coinsurance and deductible amount.

Block 1: Transmission Code - This is a number assigned by the Department of Medical Assistance Services.

Block 2: Provider Identification Number - If not preprinted, enter the 7-digit provider identification number assigned by Medicaid as well as the provider name and address.

Block 3: Recipient Name - Enter the last name and the first name of the patient as it appears on the recipient's eligibility card.

Block 4: Recipient Identification Number - Record the 12-digit number as taken from the recipient's eligibility card.

Block 5: Patient Account Number - If a provider uses a patient identification number, enter it in this block. This number will appear on the Remittance Voucher preceding the name. Otherwise leave this block blank.

Block 6: Recipient HIB Number - (Medicare number) - Enter the recipient's Medicare number.

Block 7: Primary Carrier Information Other Than Medicare Check the appropriate block. (Medicare is not the primary carrier in this situation.)

Code 2 - No Other Coverage - When there is no recipient insurance information other than Medicare, check Block 2.

Code 3 - Billed and Paid - When the recipient has other coverage that only partly satisfies the Medicare deductible and coinsurance, check Block 3 and enter the amount received from the other coverage in Block 19. If the primary carrier pays as much as the combined totals of the deductible and coinsurance, do not bill Medicaid.

Code 5 - Billed and No Coverage - When other coverage has been billed for Medicare deductible and coinsurance and the service was not covered or the benefits were exhausted, check this block and explain in "Remarks" section or attach EOB.

Block 8: Type Coverage (Medicare) Check Block A if Part A (inpatient) Medicare or Block B if Part B (outpatient) Medicare, but not both A and B.

Block 9: Diagnosis: Enter the primary ICD-9-CM diagnosis code, omitting the decimal. Only one code is processable.

Block 9A: Place of treatment. Enter the appropriate code: 1 Inpatient, 2 Outpatient, 3 Practitioners Office, 4 Patients home, 5 Nursing home, 6 Ambulance.

Block 10: Accident Indicator. Enter the appropriate box which indicates the reason treatment was rendered. Accident: possible third party recovery. Emergency: not an accident. Other - if neither of the above. Patient copay does not apply for treatment immediately following an accident or when treatment was for an emergency situation.

Block 11: Type of service. Enter the appropriate code describing the type of service: 2 Surgery, 3 Maternity, 4 Anesthesia, 5 Radiology, 6 Medical care, 8 Diagnostic examination, 9 Consultation.

Block 11A: Procedure code. For users of UB-82 and nursing home invoices, enter only the primary ICD9-CM procedure code, omitting the decimal. If no code leave blank.

For all other providers, enter the 5-digit HCPCS/CPT code which was billed to Medicare. Each procedure must be billed on a separate line. For practitioner services, if applicable, follow the 5-digit code with a hyphen and one of the following modifiers: A Professional component, B Assistant surgeon, C Concurrent care, E Technical component. If there was no procedure code billed to Medicare, leave this block blank.

Block 11B: Units/Visit Studies. Enter the units of service which were performed during the Statement Covers Period as billed to Medicare.

Block 12: Date of Admission. For hospitals and nursing homes only, enter the date of admission to the facility.

Block 13: Statement Covers Period. Enter the beginning and ending dates of service taken from the Medicare Explanation of Benefits.

Block 14: Charges to Medicare - Enter the total charges to Medicare.

Block 15: Allowed by Medicare - Enter the amount of the charges allowed by Medicare.

Block 16: Paid by Medicare - Enter the amount paid by Medicare.

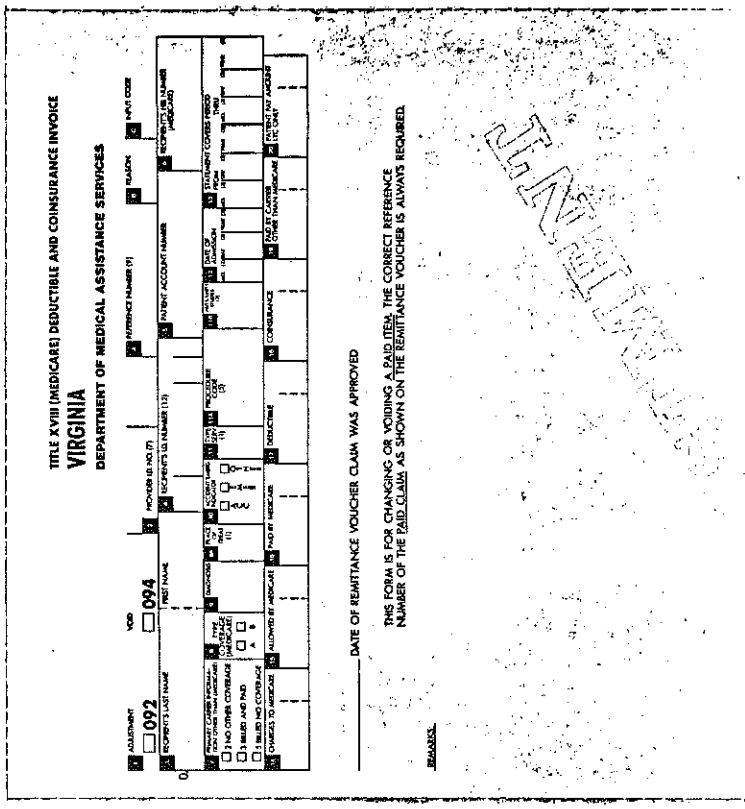
Block 17: Deductible - Enter the amount of the deductible (taken from the EOB).

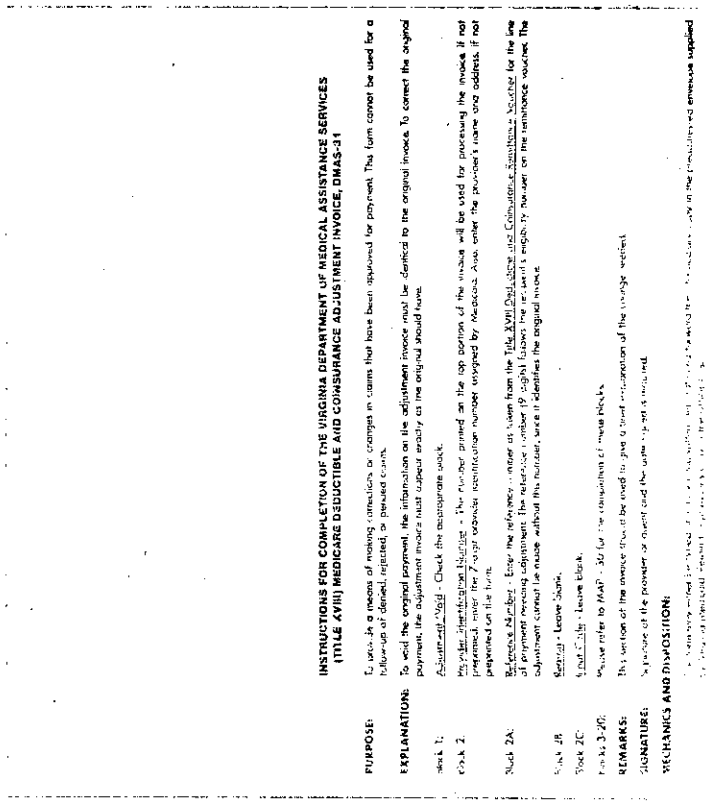
Block 18: Coinsurance - Enter the amount of coinsurance (taken from the EOB).

Block 19: Paid by Carrier Other than Medicare - If code 3 is checked in block 7, enter the payment received from carrier other than Medicare. Do not include Medicare payment.

Block 20: Patient Pay Amount, LTC Only - Long term care providers, enter the applicable patient pay amount taken from the DMAS-122 form.

Signature: Signature of the provider or agent and the date signed is required.


TITLE XVIII (MEDICARE) DEDUCTIBLE AND COINSURANCE INVOICE
VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
1 ADJUSTMENT
VOID
092
094
DATE OF REMITTANCE VOUCHER CLAIM WAS APPROVED
THIS FORM IS FOR CHANGING OR VOIDING A PAID ITEM. THE CORRECT REFERENCE NUMBER OF THE PAID CLAIM AS SHOWN ON THE REMITTANCE VOUCHER IS ALWAYS REQUIRED.
REMARKS:
THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.
SIGNATURE
DATE
ORIGINAL COPY
DMAS 31 R 1/91


INSTRUCTIONS FOR COMPLETION OF THE VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (TITLE XVIII) MEDICARE DEDUCTIBLE AND COINSURANCE ADJUSTMENT INVOICE, DMAS-31
PURPOSE:
EXPLANATION:
Item 1:
Item 2:
Item 2A:
Item 2B:
Item 2C:
Item 3-20:
REMARKS:
SIGNATURE:
MECHANICS AND DISPOSITION:

* * * * * * * *

Title of Regulation: **State Plan for Medical Assistance Relating to Specialized Care Services.**
VR 460-02-3.1300. Standards Established and Methods Used to Assure High Quality Care.
VR 460-02-4.1940. Methods and Standards for Establishing Payment Rates - Long-Term Care.
VR 460-03-4.1944. Class Resource Cost Assignment, Computation of Service Intensity Index and Ceiling and Rate Adjustments to the Prospective Direct Patient Care Operating Cost Rate - Allowance for Inflation Methodology Base "Current" Operating Rate (Appendix IV to Nursing Home Payment System).

Statutory Authority: § 32.1-325 of the Code of Virginia.

The Department of Medical Assistance Services is temporarily **WITHDRAWING** its final regulations regarding Specialized Care Services that were published in 8:16 VA.R. 2607-2626 May 4, 1992. The department intends to refile modified final regulations in the near future.

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NOTICE: Section V(7) of Attachment 4.19-A to the State Plan for Medical Assistance was amended, effective December 1, 1991, by an emergency regulation which appeared in 8:6 VA.R. 1004-1005 December 16, 1991.

Title of Regulation: **State Plan for Medical Assistance Relating to Inpatient Hospital Settlement Agreement.**
VR 460-02-4.1910. Methods and Standards for Establishing Payment Rates–Inpatient Hospital Care.

Statutory Authority: § 32.1-325 of the Code of Virginia.

Effective Date: July 1, 1992.

Summary:

This regulation will implement the requirements of the Final Settlement Agreement between the Commonwealth and the VHA.

This regulation amends the Methods and Standards for establishing payment rates, effective July 1, 1992, for inpatient hospital care services (attachment 4.19A) by establishing a Payment Adjustment Fund and by adding an additional two percentage points (200 basis points) to DMAS' prescribed inflation allowance used to calculate the prospective operating cost rate and prospective operating cost ceiling for hospitals subject to the prospective payment system of reimbursement (PPS).

In July 1982, DMAS implemented the PPS for hospitals. In March 1986, the VHA, on behalf of its member hospitals, filed suit against DMAS, challenging the Department's methodology for establishing rates for inpatient hospital services as required by the Medicaid Act (Section 1902(a) of the Social Security Act). The VHA alleged that Medicaid payments were inadequate and estimated that its member hospitals would suffer losses of $51.3 million in FY 90 as a result. The Commonwealth denied the VHA allegations and vigorously asserted its compliance with the Medicaid Act.

In December 1990, after five years of litigation, the Commonwealth and VHA agreed to an out-of-court settlement, which left DMAS' inpatient hospital reimbursement methodology intact. The agreement further provided for a Payment Adjustment Fund (PAF) in each of the Commonwealth's fiscal years during the period July 1, 1992, to June 30, 1996. The PAF is to consist of the Commonwealth's cumulative addition of $5 million in general funds along with corresponding federal financial participation for reimbursement to nonstate-owned hospitals in each of the Commonwealth's fiscal years during the period.

Additionally, the agreement provided, effective July 1, 1992, for the prescribed allowance for inflation (the HCFA-type Hospital Basket, adjusted for Virginia, as developed by Data Resources, Inc. (DRI-V)), to be converted to an escalation factor by adding two percentage points (200 basis points) to the then current DRI-V.

All 91 hospitals which participated in the VHA suit against the Commonwealth have consented to the Final Settlement and have agreed to be bound by its terms.

VR 460-02-4.1910. Methods and Standards for Establishing Payment Rates–Inpatient Hospital Care.

The state agency will pay the reasonable cost of inpatient hospital services provided under the Plan. In reimbursing hospitals for the cost of inpatient hospital services provided to recipients of medical assistance.

I. For each hospital also participating in the Health Insurance for the Aged Program under Title XVIII of the Social Security Act, the state agency will apply the same standards, cost reporting period, cost reimbursement principles, and method of cost apportionment currently used in computing reimbursement to such a hospital under Title XVIII of the Act, except that the inpatient routine services costs for medical assistance recipients will be determined subsequent to the application of the Title XVIII method of apportionment, and the calculation will exclude the applicable Title XVIII inpatient routing service charges or patient days as well as Title XVIII inpatient routine service cost.

II. For each hospital not participating in the Program under Title XVIII of the Act, the state agency will apply the standards and principles described in 42 CFR 447.250 and either (a) one of the available alternative cost apportionment methods in 42 CFR 447.250, or (b) the

"Gross RCCAC method" of cost apportionment applied as follows: For a reporting period, the total allowable hospital inpatient charges; the resulting percentage is applied to the bill of each inpatient under the Medical Assistance Program.

III. For either participating or nonparticipating facilities, the Medical Assistance Program will pay no more in the aggregate for inpatient hospital services than the amount it is estimated would be paid for the services under the Medicare principles of reimbursement, as set forth in 42 CFR 447.253(b)(2), and/or lesser of reasonable cost or customary charges in 42 CFR 447.250.

IV. The state agency will apply the standards and principles as described in the state's reimbursement plan approved by the Secretary, HHS on a demonstration or experimental basis for the payment of reasonable costs by methods other than those described in paragraphs I and II above.

V. The reimbursement system for hospitals includes the following components:

(1) Hospitals were grouped by classes according to number of beds and urban versus rural. (Three groupings for rural–0 to 100 beds, 101 to 170 beds, and over 170 beds; four groupings for urban–0 to 100, 101 to 400, 401 to 600, and over 600 beds.) Groupings are similar to those used by the Health Care Financing Administration (HCFA) in determining routine cost limitations.

(2) Prospective reimbursement ceilings on allowable operating costs were established as of July 1, 1982, for each grouping. Hospitals with a fiscal year end after June 30, 1982, were subject to the new reimbursement ceilings.

The calculation of the initial group ceilings as of July 1, 1982, was based on available, allowable cost data for all hospitals in calendar year 1981. Individual hospital operating costs were advanced by a reimbursement escalator from the hospital's year end to July 1, 1982. After this advancement, the operating costs were standardized using SMSA wage indices, and a median was determined for each group. These medians were readjusted by the wage index to set an actual cost ceiling for each SMSA. Therefore, each hospital grouping has a series of ceilings representing one of each SMSA area. The wage index is based on those used by HCFA in computing its Market Basket Index for routine cost limitations.

Effective July 1, 1986, and until June 30, 1988, providers subject to the prospective payment system of reimbursement had their prospective operating cost rate and prospective operating cost ceiling computed using a new methodology. This method uses an allowance for inflation based on the percent of change in the quarterly average of the Medical Care Index of the Chase Econometrics - Standard Forecast determined in the quarter in which the provider's new fiscal year began.

The prospective operating cost rate is based on the provider's allowable cost from the most recent filed cost report, plus the inflation percentage add-on.

The prospective operating cost ceiling is determined by using the base that was in effect for the provider's fiscal year that began between July 1, 1985, and June 1, 1986. The allowance for inflation percent of change for the quarter in which the provider's new fiscal year began is added to this base to determine the new operating cost ceiling. This new ceiling was effective for all providers on July 1, 1986. For subsequent cost reporting periods beginning on or after July 1, 1986, the last prospective operating rate ceiling determined under this new methodology will become the base for computing the next prospective year ceiling.

Effective on and after July 1, 1988, and until June 30, 1989, for providers subject to the prospective payment system, the allowance for inflation ~~will~~ *shall* be based on the percent of change in the moving average of the Data Resources, Incorporated Health Care Cost HCFA-Type Hospital Market Basket determined in the quarter in which the provider's new fiscal year begins. Such providers ~~will~~ *shall* have their prospective operating cost rate and prospective operating cost ceiling established in accordance with the methodology which became effective July 1, 1986. Rates and ceilings in effect July 1, 1988, for all such hospitals ~~will~~ *shall* be adjusted to reflect this change.

Effective on and after July 1, 1989, for providers subject to the prospective payment system, the allowance for inflation ~~will~~ *shall* be based on the percent of change in the moving average of the Health Care Cost HCFA-Type Hospital Market Basket, adjusted for Virginia *(DRI-V)* , as developed by Data Resources, Incorporated, determined in the quarter in which the provider's new fiscal year begins. Such providers ~~will~~ *shall* have their prospective operating cost rate and prospective operating cost ceiling established in accordance with the methodology which became effective July 1, 1986. Rates and ceilings in effect July 1, 1989, for all such hospitals ~~will~~ *shall* be adjusted to reflect this change.

Effective on and after July 1, 1992, for providers subject to the prospective payment system, the allowance for inflation, as described above, which became effective on July 1, 1989, shall be converted to an escalation factor by adding two percentage points (200 basis points) (DRI-V+2), to the then current allowance for inflation. The escalation factor shall be applied in accordance with the current inpatient hospital reimbursement methodology. On July 1, 1992, the conversion to the new escalation factor shall be accomplished by a transition

methodology which, for non-June 30 year end hospitals, applies the escalation factor to escalate their payment rates for the months between July 1, 1992, and their next fiscal year ending on or before May 31, 1993.

The new method ~~will~~ *shall* still require comparison of the prospective operating cost rate to the prospective operating ceiling. The provider is allowed the lower of the two amounts subject to the lower of cost or charges principles.

(3) Subsequent to June 30, [~~1982~~ *1992*], the group ceilings ~~should~~ *shall* not be recalculated on allowable costs, but ~~should~~ *shall* be updated by the escalator.

(4) Prospective rates for each hospital ~~should~~ *shall* be based upon the hospital's allowable costs plus the escalator, or the appropriate ceilings, or charges; whichever is lower. Except to eliminate costs that are found to be unallowable, no retrospective adjustment ~~should~~ *shall* be made to prospective rates.

Depreciation, capital interest, and education costs approved pursuant to ~~HIM~~ *PRM* -15 (Sec. 400), ~~should~~ *shall* be considered as pass throughs and not part of the calculation.

(5) An incentive plan ~~should~~ *shall* be established whereby a hospital will be paid on a sliding scale, percentage for percentage, up to 25% of the difference between allowable operating costs and the appropriate per diem group ceiling when the operating costs are below the ceilings. The incentive ~~should~~ *shall* be calculated based on the annual cost report.

The table below presents three examples under the new plan:

Group Ceiling	Hospital's Allowable Cost Per Day	Difference $	% of Ceiling	Sliding Scale Incentive $	% of Difference
$230	$230	0	0	0	0
$230	207	23.00	10%	2.30	10%
$230	172	57.50	25%	14.38	25%
$230	143	76.00	33%	19.00	25%

(6) There ~~will~~ *shall* be special consideration for exception to the median operating cost limits in those instances where extensive neonatal care is provided.

(7) Hospitals which have a disproportionately higher level of Medicaid patients and which exceed the ceiling shall be allowed a higher ceiling based on the individual hospital's Medicaid utilization. This shall be measured by the percent of Medicaid patient days to total hospital patient days. Each hospital with a Medicaid utilization of over 8.0% shall receive an adjustment to its ceiling. The adjustment shall be set at a percent added to the ceiling for each percent of utilization up to 30%.

Disproportionate share hospitals defined.

Effective July 1, 1988,[1] the following criteria shall be met before a hospital is determined to be eligible for a disproportionate share payment adjustment.

A. Criteria.

1. A Medicaid inpatient utilization rate in excess of 8.0% for hospitals receiving Medicaid payments in the Commonwealth, 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. Subsection A 2 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.

B. Payment adjustment.

1. Hospitals which have a disproportionately higher level of Medicaid patients shall be allowed a disproportionate share payment adjustment based on the individual hospital's Medicaid utilization. The Medicaid utilization shall be determined by dividing the total number of Medicaid inpatient days by the number of inpatient days. Each hospital with a Medicaid utilization of over 8.0% shall receive a disproportionate share payment adjustment. The disproportionate share payment adjustment shall be equal to the product of (i) the hospital's Medicaid utilization in excess of 8.0%, times (ii) the lower of the prospective operating cost rate or ceiling.

2. A payment adjustment for hospitals meeting the eligibility criteria in subsection A above and calculated under subsection B 1 above shall be phased in over a 3-year period. As of July 1, 1988,[2] the adjustment shall be at least one-third the amount of the full payment adjustment; as of July 1, 1989, the payment shall be at least two-thirds the full payment adjustment; and as of July 1, 1990, the payment shall be the full amount of the payment adjustment. However, for each year of the phase-in period, no hospital shall receive a disproportionate share payment adjustment which is

less than it would have received if the payment had been calculated pursuant to § V (5) of Attachment 4.19A to the State Plan in effect before July 1, 1988.

(8) DMAS shall pay to disproportionate share hospitals (as defined in § V (7) above) an outlier adjustment in payment amounts for medically necessary inpatient hospital services provided on or after July 1, 1989, involving exceptionally high costs for individuals under one year of age. The adjustment shall be calculated as follows:

(a) Each eligible hospital which desires to be considered for the adjustment shall submit a log which contains the information necessary to compute the mean of its Medicaid per diem operating cost of treating individuals under one year of age. This log shall contain all Medicaid claims for such individuals, including, but not limited to: (i) the patient's name and Medicaid identification number; (ii) dates of service; (iii) the remittance date paid; (iv) the number of covered days; and (v) total charges for the length of stay. Each hospital shall then calculate the per diem operating cost (which excludes capital and education) of treating such patients by multiplying the charge for each patient by the Medicaid operating cost-to-charge ratio determined from its annual cost report.

(b) Each eligible hospital shall calculate the mean of its Medicaid per diem operating cost of treating individuals under one year of age. Any hospital which qualifies for the extensive neonatal care provision (as governed by § V (6) above) shall calculate a separate mean for the cost of providing extensive neonatal care to individuals under one year of age.

(c) Each eligible hospital shall calculate its threshold for payment of the adjustment, at a level equal to two and one-half standard deviations above the mean or means calculated in subdivision (b) above.

(d) DMAS shall pay as an outlier adjustment to each eligible hospital all per diem operating costs which exceed the applicable threshold or thresholds for that hospital.

Pursuant to section 1 of Supplement 1 to Attachment 3.1 A and B, there is no limit on length of time for medically necessary stays for individuals under one year of age.

VI. In accordance with Title 42 §§ 447.250 through 447.272 of the Code of Federal Regulations which implements § 1902(a)(13)(A) of the Social Security Act, the Department of Medical Assistance Services ("DMAS") establishes payment rates for services that are reasonable and adequate to meet the costs that shall be incurred by efficiently and economically operated facilities to provide services in conformity with state and federal laws, regulations, and quality and safety standards. To establish these rates Virginia uses the Medicare principles of cost reimbursement in determining the allowable costs for Virginia's prospective payment system. Allowable costs will be determined from the filing of a uniform cost report by participating providers. The cost reports are due not later than 90 days after the provider's fiscal year end. If a complete cost report is not received within 90 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), a statement of changes in financial position, and footnotes to the financial statements;

4. Schedules which reconcile financial statements and trial balance to expenses claimed in the cost report;

5. Home office cost report, if applicable; and

6. Such other analytical information or supporting documents requested by DMAS when the cost reporting forms are sent to the provider.

Although utilizing the cost apportionment and cost finding methods of the Medicare Program, Virginia does not adopt the prospective payment system of the Medicare Program enacted October 1, 1983.

VII. Revaluation of assets.

A. Effective October 1, 1984, the valuation of an asset of a hospital or long-term care facility which has undergone a change of ownership on or after July 18, 1984, shall be the lesser of the allowable acquisition cost to the owner of record as of July 18, 1984, or the acquisition cost to the new owner.

B. In the case of an asset not in existence as of July 18, 1984, the valuation of an asset of a hospital or long-term care facility shall be the lesser of the first owner of record, or the acquisition cost to the new owner.

C. In establishing an appropriate allowance for depreciation, interest on capital indebtedness, and return on equity (if applicable prior to July 1, 1986) the base to be used for such computations shall be limited to A or B above.

D. Costs (including legal fees, accounting and

administrative costs, travel costs, and feasibility studies) attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) shall be reimbursable only to the extent that they have not been previously reimbursed by Medicaid.

E. The recapture of depreciation up to the full value of the asset is required.

F. Rental charges in sale and leaseback agreements shall be restricted to the depreciation, mortgage interest and (if applicable prior to July 1, 1986) return on equity based on cost of ownership as determined in accordance with A and B above.

VIII. Refund of overpayments.

A. Lump sum payment.

When the provider files a cost report indicating that an overpayment has occurred, full refund shall be remitted with the cost report. In cases where DMAS discovers an overpayment during desk review, field audit, or final settlement, DMAS shall promptly send the first demand letter requesting a lump sum refund. Recovery shall be undertaken even though the provider disputes in whole or in part DMAS's determination of the overpayment.

B. Offset.

If the provider has been overpaid for a particular fiscal year and has been underpaid for another fiscal year, the underpayment shall be offset against the overpayment. So long as the provider has an overpayment balance, any underpayments discovered by subsequent review or audit shall also be used to reduce the remaining amount of the overpayment.

C. Payment schedule.

If the provider cannot refund the total amount of the overpayment (i) at the time it files a cost report indicating that an overpayment has occurred, the provider shall request an extended repayment schedule at the time of filing, or (ii) within 30 days after receiving the DMAS demand letter, the provider shall promptly request an extended repayment schedule.

DMAS may establish a repayment schedule of up to 12 months to recover all or part of an overpayment or, if a provider demonstrates that repayment within a 12-month period would create severe financial hardship, the Director of the Department of Medical Assistance Services ("the director") may approve a repayment schedule of up to 36 months.

A provider shall have no more than one extended repayment schedule in place at one time. If an audit later uncovers an additional overpayment, the full amount shall be repaid within 30 days unless the provider submits further documentation supporting a modification to the existing extended repayment schedule to include the additional amount.

If, during the time an extended repayment schedule is in effect, the provider withdraws from the Program or fails to file a cost report in a timely manner, the outstanding balance shall become immediately due and payable.

When a repayment schedule is used to recover only part of an overpayment, the remaining amount shall be recovered by the reduction of interim payments to the provider or by lump sum payments.

D. Extension request documentation.

In the request for an extended repayment schedule, the provider shall document the need for an extended (beyond 30 days) repayment and submit a written proposal scheduling the dates and amounts of repayments. If DMAS approves the schedule, DMAS shall send the provider written notification of the approved repayment schedule, which shall be effective retroactive to the date the provider submitted the proposal.

E. Interest charge on extended repayment.

Once an initial determination of overpayment has been made, DMAS shall undertake full recovery of such overpayment whether or not the provider disputes, in whole or in part, the initial determination of overpayment. If an appeal follows, interest shall be waived during the period of administrative appeal of an initial determination of overpayment.

Interest charges on the unpaid balance of any overpayment shall accrue pursuant to § 32.1-313 of the Code of Virginia from the date the director's determination becomes final.

The director's determination shall be deemed to be final on (i) the due date of any cost report filed by the provider indicating that an overpayment has occurred, or (ii) the issue date of any notice of overpayment, issued by DMAS, if the provider does not file an appeal, or (iii) the issue date of any administrative decision issued by DMAS after an informal factfinding conference, if the provider does not file an appeal, or (iv) the issue date of any administrative decision signed by the director, regardless of whether a judicial appeal follows. In any event, interest shall be waived if the overpayment is completely liquidated within 30 days of the date of the final determination. In cases in which a determination of overpayment has been judicially reversed, the provider shall be reimbursed that portion of the payment to which it is entitled, plus any applicable interest which the provider paid to DMAS.

IX. Effective October 1, 1986, hospitals that have obtained Medicare certification as inpatient rehabilitation hospitals or rehabilitation units in acute care hospitals,

which are exempted from the Medicare Prospective Payment System (DRG), shall be reimbursed in accordance with the current Medicaid Prospective Payment System as described in the preceding sections I, II, III, IV, V, VI, VII, VIII and excluding V(6). Additionally, rehabilitation hospitals and rehabilitation units of acute care hospitals which are exempt from the Medicare Prospective Payment System will be required to maintain separate cost accounting records, and to file separate cost reports annually utilizing the applicable Medicare cost reporting forms (HCFA 2552 series) and the Medicaid forms (MAP-783 series).

A new facility shall have an interim rate determined using a pro forma cost report or detailed budget prepared by the provider and accepted by the DMAS, which represents its anticipated allowable cost for the first cost reporting period of participation. For the first cost reporting period, the provider will be held to the lesser of its actual operating cost or its peer group ceiling. Subsequent rates will be determined in accordance with the current Medicaid Prospective Payment System as noted in the preceding paragraph of IX.

X. Item 398 D of the 1987 Appropriation Act (as amended), effective April 8, 1987, eliminated reimbursement of return on equity capital to proprietary providers.

XI. Pursuant to Item 389 E4 of the 1988 Appropriation Act (as amended), effective July 1, 1988, a separate group ceiling for allowable operating costs shall be established for state-owned university teaching hospitals.

XII. Nonenrolled providers.

A. Hospitals that are not enrolled as providers with the Department of Medical Assistance Services (DMAS) which submit claims shall be paid based on the DMAS average reimbursable inpatient cost-to-charge ratio, updated annually, for enrolled hospitals less five percent. The five percent is for the cost of the additional manual processing of the claims. Hospitals that are not enrolled shall submit claims using the required DMAS invoice formats. Such claims must be submitted within 12 months from date of services. A hospital is determined to regularly treat Virginia Medicaid recipients and shall be required by DMAS to enroll if it provides more than 500 days of care to Virginia Medicaid recipients during the hospitals' financial fiscal year. A hospital which is required by DMAS to enroll shall be reimbursed in accordance with the current Medicaid Prospective Payment System as described in the preceding Sections I, II, III, IV, V, VI, VII, VIII, IX, and X. The hospital shall be placed in one of the DMAS peer groupings which most nearly reflects its licensed bed size and location (Section V.(1) above). These hospitals shall be required to maintain separate cost accounting records, and to file separate cost reports annually, utilizing the applicable Medicare cost reporting forms, (HCFA 2552 Series) and the Medicaid forms (MAP-783 Series).

B. A newly enrolled facility shall have an interim rate determined using the provider's most recent filed Medicare cost report or a pro forma cost report or detailed budget prepared by the provider and accepted by DMAS, which represents its anticipated allowable cost for the first cost reporting period of participation. For the first cost reporting period, the provider shall be limited to the lesser of its actual operating costs or its peer group ceiling. Subsequent rates shall be determined in accordance with the current Medicaid Prospective Payment System as noted in the preceding paragraph of XII.A.

C. Once a hospital has obtained the enrolled status, 500 days of care, the hospital must agree to become enrolled as required by DMAS to receive reimbursement. This status shall continue during the entire term of the provider's current Medicare certification and subsequent recertification or until mutually terminated with 30 days written notice by either party. The provider must maintain this enrolled status to receive reimbursement. If an enrolled provider elects to terminate the enrolled agreement, the nonenrolled reimbursement status will not be available to the hospital for future reimbursement, except for emergency care.

D. Prior approval must be received from the DMAS Health Services Review Division when a referral has been made for treatment to be received from a nonenrolled acute care facility (in-state or out-of-state), except in the case of an emergency or because medical resources or supplementary resources are more readily available in another state.

E. Nothing in this regulation is intended to preclude DMAS from reimbursing for special services, such as rehabilitation, ventilator, and transplantation, on an exception basis and reimbursing for these services on an individually, negotiated rate basis.

XIII. Payment Adjustment Fund.

A. A Payment Adjustment Fund shall be created in each of the Commonwealth's fiscal years during the period July 1, 1992, to June 30, 1996. The Payment Adjustment Fund shall consist of the Commonwealth's cumulative addition of $5 million in general funds and its corresponding federal financial participation for reimbursement to nonstate-owned hospitals in each of the Commonwealth's fiscal years during this period. Each July 1, or as soon thereafter as is reasonably possible, the Commonwealth shall, through a single payment to each nonstate-owned hospital, equitably and fully disburse the Payment Adjustment Fund for that year.

B. In the absence of any amendment to the State Plan, Attachment 4.19A, for the Commonwealth's fiscal year after 1996, the Payment Adjustment Fund shall be continued at the level established in 1996 and shall be disbursed in accordance with the methodology described below.

C. The Payment Adjustment Funds shall be disbursed in accordance with the following methodology:

1. Identify each nonstate-owned hospital provider (acute, neonatal and rehabilitation) receiving payment based upon its peer group operating ceiling in May of each year.

2. For each such hospital identified in subdivision 1, identify its Medicaid paid days for the 12 months ending each May 31.

3. Multiply each such hospital's days under subdivision 2 by such hospital's May individual peer group ceiling (i.e, disregarding such hospital's actual fiscal year end ceiling) as adjusted by its then current disproportionate share factor.

4. Sum all hospital amounts determined in subdivision 3.

5. For each such hospital, divide its amount determined in subdivision 3 by the total of such amounts determined in subdivision 4. This then becomes the hospital adjustment factor ("HAF") for each such hospital.

6. Multiply each such hospital's HAF times the amount of the Payment Adjustment Fund ("PAF") to determine its potential PAF share.

7. Determine the unreimbursed Medicaid allowable operating cost per day for each such hospital in subdivision 1 for the most recent fiscal year on file at DMAS as of May 31, inflate such costs by DRI-V+2 from the midpoint of such cost report to May 31 and multiply such inflated costs per day by the days identified for that hospital in subdivision 2, creating the "unreimbursed amount."

8. Compare each such hospital's potential PAF share to its unreimbursed amount.

9. Allocate to all hospitals, where the potential PAF share exceeds the unreimbursed amount, such hospital's unreimbursed amount as its actual PAF share.

10. If the PAF is not exhausted, for those hospitals with an unreimbursed amount balance, recalculate a new HAF for each such hospital by dividing the hospital's HAF by the total of the HAFs for all hospitals with an unreimbursed amount balance.

11. Recompute each hospital's new potential share of the undisbursed PAF by multiplying such funds by each hospital's new HAF.

12. Compare each hospital's new potential PAF share to its unreimbursed amount. If the unreimbursed amounts exceed the PAF shares at all hospitals, each hospital's new PAF share becomes its actual PAF share. If some hospitals' unreimbursed amounts are less than the new potential PAF shares, allocate to such hospitals their unreimbursed amount as their actual PAF share. Then, for those hospitals with an unreimbursed amount balance, repeat steps 10, 11 and 12 until each hospital's actual PAF share is determined and the PAF is exhausted.

13. The annual payment to be made to each nonstate-owned hospital from the PAF shall be equal to their actual PAF share as determined and allocated above. Each hospital's actual PAF share payment shall be made on July 1, or as soon thereafter as is reasonably feasible.

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NOTICE: Section V(7) of Attachment 4.19-A to the State Plan for Medical Assistance was amended, effective December 1, 1991, by an emergency regulation which appeared in 8:6 VA.R. 1004-1005 December 16, 1991.

Title of Regulation: **State Plan for Medical Assistance Relating to Inpatient Outlier Adjustments.**
VR 460-02-4.1910. Methods and Standards for Establishing Payment Rates–Inpatient Hospital Care.

Statutory Authority: § 32.1-325 of the Code of Virginia.

Effective Date: July 1, 1992.

Summary:

The purpose of this amendment is to promulgate permanent regulations to supersede the existing emergency regulations.

The section of the State Plan affected by this action is the Methods and Standards for Establishing Payment Rates–Inpatient Hospital Care (Attachment 4.19A).

The Omnibus Budget Reconciliation Act of 1990 (OBRA 90) § 4604 required that State Plans, which reimburse inpatient hospital services on a prospective basis, provide for an outlier adjustment payment for certain medically necessary inpatient hospital services. Specifically, these services involve exceptionally high costs or exceptionally long lengths of stay for (i) infants younger than one year of age in all hospitals, and (ii) children younger than one year of age in disproportionate share hospitals. The Plan, prior to the existing emergency regulation, provided for an outlier adjustment for exceptionally high costs for infants younger than one year of age in disproportionate share hospitals only.

Supplement 1 to Attachment 3.1 A & B (the Amount, Duration, and Scope of Services) currently provides for unlimited medically necessary days for children

younger than 21 years because of the well child screening program (Early and Periodic Screening, Diagnosis, and Treatment). This language is being incorporated into Attachment 4.19 A at the direction of the Health Care Financing Administration.

VR 460-02-4.1910. Methods and Standards for Establishing Payment

The state agency will pay the reasonable cost of inpatient hospital services provided under the Plan. In reimbursing hospitals for the cost of inpatient hospital services provided to recipients of medical assistance.

I. For each hospital also participating in the Health Insurance for the Aged Program under Title XVIII of the Social Security Act, the state agency will apply the same standards, cost reporting period, cost reimbursement principles, and method of cost apportionment currently used in computing reimbursement to such a hospital under Title XVIII of the Act, except that the inpatient routine services costs for medical assistance recipients will be determined subsequent to the application of the Title XVIII method of apportionment, and the calculation will exclude the applicable Title XVIII inpatient routing service charges or patient days as well as Title XVIII inpatient routine service cost.

II. For each hospital not participating in the Program under Title XVIII of the Act, the state agency will apply the standards and principles described in 42 CFR 447.250 and either (a) one of the available alternative cost apportionment methods in 42 CFR 447.250, or (b) the "Gross RCCAC method" of cost apportionment applied as follows: For a reporting period, the total allowable hospital inpatient charges; the resulting percentage is applied to the bill of each inpatient under the Medical Assistance Program.

III. For either participating or nonparticipating facilities, the Medical Assistance Program will pay no more in the aggregate for inpatient hospital services than the amount it is estimated would be paid for the services under the Medicare principles of reimbursement, as set forth in 42 CFR 447.253(b)(2), and/or lesser of reasonable cost or customary charges in 42 CFR 447.250.

IV. The state agency will apply the standards and principles as described in the state's reimbursement plan approved by the Secretary, HHS on a demonstration or experimental basis for the payment of reasonable costs by methods other than those described in paragraphs I and II above.

V. The reimbursement system for hospitals includes the following components:

(1) Hospitals were grouped by classes according to number of beds and urban versus rural. (Three groupings for rural–0 to 100 beds, 101 to 170 beds, and over 170 beds; four groupings for urban–0 to 100, 101 to 400, 401 to 600, and over 600 beds.) Groupings are similar to those used by the Health Care Financing Administration (HCFA) in determining routine cost limitations.

(2) Prospective reimbursement ceilings on allowable operating costs were established as of July 1, 1982, for each grouping. Hospitals with a fiscal year end after June 30, 1982, were subject to the new reimbursement ceilings.

The calculation of the initial group ceilings as of July 1, 1982, was based on available, allowable cost data for all hospitals in calendar year 1981. Individual hospital operating costs were advanced by a reimbursement escalator from the hospital's year end to July 1, 1982. After this advancement, the operating costs were standardized using SMSA wage indices, and a median was determined for each group. These medians were readjusted by the wage index to set an actual cost ceiling for each SMSA. Therefore, each hospital grouping has a series of ceilings representing one of each SMSA area. The wage index is based on those used by HCFA in computing its Market Basket Index for routine cost limitations.

Effective July 1, 1986, and until June 30, 1988, providers subject to the prospective payment system of reimbursement had their prospective operating cost rate and prospective operating cost ceiling computed using a new methodology. This method uses an allowance for inflation based on the percent of change in the quarterly average of the Medical Care Index of the Chase Econometrics - Standard Forecast determined in the quarter in which the provider's new fiscal year began.

The prospective operating cost rate is based on the provider's allowable cost from the most recent filed cost report, plus the inflation percentage add-on.

The prospective operating cost ceiling is determined by using the base that was in effect for the provider's fiscal year that began between July 1, 1985, and June 1, 1986. The allowance for inflation percent of change for the quarter in which the provider's new fiscal year began is added to this base to determine the new operating cost ceiling. This new ceiling was effective for all providers on July 1, 1986. For subsequent cost reporting periods beginning on or after July 1, 1986, the last prospective operating rate ceiling determined under this new methodology will become the base for computing the next prospective year ceiling.

Effective on and after July 1, 1988, and until June 30, 1989, for providers subject to the prospective payment system, the allowance for inflation will be based on the percent of change in the moving average of the Data Resources, Incorporated Health Care Cost HCFA-Type Hospital Market Basket determined in the quarter in which the provider's new fiscal year begins.

Such providers will have their prospective operating cost rate and prospective operating cost ceiling established in accordance with the methodology which became effective July 1, 1986. Rates and ceilings in effect July 1, 1988, for all such hospitals will be adjusted to reflect this change.

Effective on and after July 1, 1989, for providers subject to the prospective payment system, the allowance for inflation will be based on the percent of change in the moving average of the Health Care Cost HCFA-Type Hospital Market Basket, adjusted for Virginia, as developed by Data Resources, Incorporated, determined in the quarter in which the provider's new fiscal year begins. Such providers will have their prospective operating cost rate and prospective operating cost ceiling established in accordance with the methodology which became effective July 1, 1986. Rates and ceilings in effect July 1, 1989, for all such hospitals will be adjusted to reflect this change.

The new method will still require comparison of the prospective operating cost rate to the prospective operating ceiling. The provider is allowed the lower of the two amounts subject to the lower of cost or charges principles.

(3) Subsequent to June 30, 1982, the group ceilings should not be recalculated on allowable costs, but should be updated by the escalator.

(4) Prospective rates for each hospital should be based upon the hospital's allowable costs plus the escalator, or the appropriate ceilings, or charges; whichever is lower. Except to eliminate costs that are found to be unallowable, no retrospective adjustment should be made to prospective rates.

Depreciation, capital interest, and education costs approved pursuant to HIM-15 (Sec. 400), should be considered as pass throughs and not part of the calculation.

(5) An incentive plan should be established whereby a hospital will be paid on a sliding scale, percentage for percentage, up to 25% of the difference between allowable operating costs and the appropriate per diem group ceiling when the operating costs are below the ceilings. The incentive should be calculated based on the annual cost report.

The table below presents three examples under the new plan:

Group Ceiling	Hospital's Allowable Cost Per Day $	Difference $	Difference % of Ceiling	Sliding Scale Incentive $	Sliding Scale Incentive % of Difference
$230	$230	0	0	0	0
$230	207	23.00	10%	2.30	10%
$230	172	57.50	25%	14.38	25%
$230	143	76.00	33%	19.00	25%

(6) There will be special consideration for exception to the median operating cost limits in those instances where extensive neonatal care is provided.

(7) Hospitals which have a disproportionately higher level of Medicaid patients and which exceed the ceiling shall be allowed a higher ceiling based on the individual hospital's Medicaid utilization. This shall be measured by the percent of Medicaid patient days to total hospital patient days. Each hospital with a Medicaid utilization of over 8.0% shall receive an adjustment to its ceiling. The adjustment shall be set at a percent added to the ceiling for each percent of utilization up to 30%.

Disproportionate share hospitals defined.

Effective July 1, 1988,[1] the following criteria shall be met before a hospital is determined to be eligible for a disproportionate share payment adjustment.

A. Criteria.

1. A Medicaid inpatient utilization rate in excess of 8.0% for hospitals receiving Medicaid payments in the Commonwealth, 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. Subsection A 2 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.

B. Payment adjustment.

1. Hospitals which have a disproportionately higher level of Medicaid patients shall be allowed a disproportionate share payment adjustment based on the individual hospital's Medicaid utilization. The Medicaid utilization shall be determined by dividing the total number of Medicaid inpatient days by the number of inpatient days. Each hospital with a

Medicaid utilization of over 8.0% shall receive a disproportionate share payment adjustment. The disproportionate share payment adjustment shall be equal to the product of (i) the hospital's Medicaid utilization in excess of 8.0%, times (ii) the lower of the prospective operating cost rate or ceiling.

2. A payment adjustment for hospitals meeting the eligibility criteria in subsection A above and calculated under subsection B 1 above shall be phased in over a 3-year period. As of July 1, 1988,[2] the adjustment shall be at least one-third the amount of the full payment adjustment; as of July 1, 1989, the payment shall be at least two-thirds the full payment adjustment; and as of July 1, 1990, the payment shall be the full amount of the payment adjustment. However, for each year of the phase-in period, no hospital shall receive a disproportionate share payment adjustment which is less than it would have received if the payment had been calculated pursuant to § V (5) of Attachment 4.19A to the State Plan in effect before July 1, 1988.

~~(8) DMAS shall pay to disproportionate share hospitals (as defined in § V (7) above) an outlier adjustment in payment amounts for medically necessary inpatient hospital services provided on or after July 1, 1989, involving exceptionally high costs for individuals under one year of age. The adjustment shall be calculated as follows:~~

~~(a) Each eligible hospital which desires to be considered for the adjustment shall submit a log which contains the information necessary to compute the mean of its Medicaid per diem operating cost of treating individuals under one year of age. This log shall contain all Medicaid claims for such individuals, including, but not limited to: (i) the patient's name and Medicaid identification number; (ii) dates of service; (iii) the remittance date paid; (iv) the number of covered days; and (v) total charges for the length of stay. Each hospital shall then calculate the per diem operating cost (which excludes capital and education) of treating such patients by multiplying the charge for each patient by the Medicaid operating cost-to-charge ratio determined from its annual cost report.~~

~~(b) Each eligible hospital shall calculate the mean of its Medicaid per diem operating cost of treating individuals under one year of age. Any hospital which qualifies for the extensive neonatal care provision (as governed by § V (6) above) shall calculate a separate mean for the cost of providing extensive neonatal care to individuals under one year of age.~~

~~(c) Each eligible hospital shall calculate its threshold for payment of the adjustment, at a level equal to two and one-half standard deviations above the mean or means calculated in subdivision (b) above.~~

~~(d) DMAS shall pay as an outlier adjustment to each eligible hospital all per diem operating costs which exceed the applicable threshold or thresholds for that hospital.~~

~~Pursuant to section 1 of Supplement 1 to Attachment 3.1 A and B, there is no limit on length of time for medically necessary stays for individuals under one year of age.~~

(8) Outlier adjustments.

a. DMAS shall pay to all enrolled hospitals an outlier adjustment in payment amounts for medically necessary inpatient hospital services provided on or after July 1, 1991, involving exceptionally high costs for individuals under one year of age.

b. DMAS shall pay to disproportionate share hospitals (as defined in V (7) above) an outlier adjustment in payment amount for medically necessary inpatient hospital services provided on or after July 1, 1991, involving exceptionally high costs for individuals under six years of age.

c. The outlier adjustment calculation.

(1) Each eligible hospital which desires to be considered for the adjustment shall submit a log which contains the information necessary to compute the mean of its Medicaid per diem operating cost of treating individuals identified in (8) a or b above. This log shall contain all Medicaid claims for such individuals, including, but not limited to: (i) the patient's name and Medicaid identification number; (ii) dates of service; (iii) the remittance date paid; (iv) the number of covered days; and (v) total charges for the length of stay. Each hospital shall then calculate the per diem operating cost (which excludes capital and education) of treating such patients by multiplying the charge for each patient by the Medicaid operating cost-to-charge ratio determined from its annual cost report.

(2) Each eligible hospital shall calculate the mean of its Medicaid per diem operating cost of treating individuals identified in (8) a or b above. Any hospital which qualifies for the extensive neonatal care provision (as governed by V (6) above) shall calculate a separate mean for the cost of providing extensive neonatal care to individuals identified in (8) a or b above.

(3) Each eligible hospital shall calculate its threshold for payment of the adjustment, at a level equal to two and one-half standard deviations above the mean or means calculated in (8) c (2) above.

(4) DMAS shall pay as an outlier adjustment to each eligible hospital all per diem operating costs

which exceed the applicable threshold or thresholds for that hospital.

d. Pursuant to § 1 of Supplement 1 to Attachment 3.1 A & B, there is no limit on length of time for medically necessary stays for individuals under six years of age. This section provides that consistent with the EPSDT program referred to in 42 CFR 441.57, 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 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. Medical documentation justifying admission and the continued length of stay must be attached to or written on the invoice for review by medical staff to determine medical necessity. Medically unjustified days in such admissions will be denied.

VI. In accordance with Title 42 §§ 447.250 through 447.272 of the Code of Federal Regulations which implements § 1902(a)(13)(A) of the Social Security Act, the Department of Medical Assistance Services ("DMAS") establishes payment rates for services that are reasonable and adequate to meet the costs that shall be incurred by efficiently and economically operated facilities to provide services in conformity with state and federal laws, regulations, and quality and safety standards. To establish these rates Virginia uses the Medicare principles of cost reimbursement in determining the allowable costs for Virginia's prospective payment system. Allowable costs will be determined from the filing of a uniform cost report by participating providers. The cost reports are due not later than 90 days after the provider's fiscal year end. If a complete cost report is not received within 90 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), a statement of changes in financial position, and footnotes to the financial statements;

4. Schedules which reconcile financial statements and trial balance to expenses claimed in the cost report;

5. Home office cost report, if applicable; and

6. Such other analytical information or supporting documents requested by DMAS when the cost reporting forms are sent to the provider.

Although utilizing the cost apportionment and cost finding methods of the Medicare Program, Virginia does not adopt the prospective payment system of the Medicare Program enacted October 1, 1983.

VII. Revaluation of assets.

A. Effective October 1, 1984, the valuation of an asset of a hospital or long-term care facility which has undergone a change of ownership on or after July 18, 1984, shall be the lesser of the allowable acquisition cost to the owner of record as of July 18, 1984, or the acquisition cost to the new owner.

B. In the case of an asset not in existence as of July 18, 1984, the valuation of an asset of a hospital or long-term care facility shall be the lesser of the first owner of record, or the acquisition cost to the new owner.

C. In establishing an appropriate allowance for depreciation, interest on capital indebtedness, and return on equity (if applicable prior to July 1, 1986) the base to be used for such computations shall be limited to A or B above.

D. Costs (including legal fees, accounting and administrative costs, travel costs, and feasibility studies) attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) shall be reimbursable only to the extent that they have not been previously reimbursed by Medicaid.

E. The recapture of depreciation up to the full value of the asset is required.

F. Rental charges in sale and leaseback agreements shall be restricted to the depreciation, mortgage interest and (if applicable prior to July 1, 1986) return on equity based on cost of ownership as determined in accordance with A and B above.

VIII. Refund of overpayments.

A. Lump sum payment.

When the provider files a cost report indicating that an overpayment has occurred, full refund shall be remitted with the cost report. In cases where DMAS discovers an overpayment during desk review, field audit, or final settlement, DMAS shall promptly send the first demand letter requesting a lump sum refund. Recovery shall be undertaken even though the provider disputes in whole or in part DMAS's determination of the overpayment.

B. Offset.

If the provider has been overpaid for a particular fiscal year and has been underpaid for another fiscal year, the underpayment shall be offset against the overpayment. So

ong as the provider has an overpayment balance, any underpayments discovered by subsequent review or audit shall also be used to reduce the remaining amount of the overpayment.

C. Payment schedule.

If the provider cannot refund the total amount of the overpayment (i) at the time it files a cost report indicating that an overpayment has occurred, the provider shall request an extended repayment schedule at the time of filing, or (ii) within 30 days after receiving the DMAS demand letter, the provider shall promptly request an extended repayment schedule.

DMAS may establish a repayment schedule of up to 12 months to recover all or part of an overpayment or, if a provider demonstrates that repayment within a 12-month period would create severe financial hardship, the Director of the Department of Medical Assistance Services ("the director") may approve a repayment schedule of up to 36 months.

A provider shall have no more than one extended repayment schedule in place at one time. If an audit later uncovers an additional overpayment, the full amount shall be repaid within 30 days unless the provider submits further documentation supporting a modification to the existing extended repayment schedule to include the additional amount.

If, during the time an extended repayment schedule is in effect, the provider withdraws from the Program or fails to file a cost report in a timely manner, the outstanding balance shall become immediately due and payable.

When a repayment schedule is used to recover only part of an overpayment, the remaining amount shall be recovered by the reduction of interim payments to the provider or by lump sum payments.

D. Extension request documentation.

In the request for an extended repayment schedule, the provider shall document the need for an extended (beyond 30 days) repayment and submit a written proposal scheduling the dates and amounts of repayments. If DMAS approves the schedule, DMAS shall send the provider written notification of the approved repayment schedule, which shall be effective retroactive to the date the provider submitted the proposal.

E. Interest charge on extended repayment.

Once an initial determination of overpayment has been made, DMAS shall undertake full recovery of such overpayment whether or not the provider disputes, in whole or in part, the initial determination of overpayment. If an appeal follows, interest shall be waived during the period of administrative appeal of an initial determination of overpayment.

Interest charges on the unpaid balance of any overpayment shall accrue pursuant to § 32.1-313 of the Code of Virginia from the date the director's determination becomes final.

The director's determination shall be deemed to be final on (i) the due date of any cost report filed by the provider indicating that an overpayment has occurred, or (ii) the issue date of any notice of overpayment, issued by DMAS, if the provider does not file an appeal, or (iii) the issue date of any administrative decision issued by DMAS after an informal factfinding conference, if the provider does not file an appeal, or (iv) the issue date of any administrative decision signed by the director, regardless of whether a judicial appeal follows. In any event, interest shall be waived if the overpayment is completely liquidated within 30 days of the date of the final determination. In cases in which a determination of overpayment has been judicially reversed, the provider shall be reimbursed that portion of the payment to which it is entitled, plus any applicable interest which the provider paid to DMAS.

IX. Effective October 1, 1986, hospitals that have obtained Medicare certification as inpatient rehabilitation hospitals or rehabilitation units in acute care hospitals, which are exempted from the Medicare Prospective Payment System (DRG), shall be reimbursed in accordance with the current Medicaid Prospective Payment System as described in the preceding sections I, II, III, IV, V, VI, VII, VIII and excluding V(6). Additionally, rehabilitation hospitals and rehabilitation units of acute care hospitals which are exempt from the Medicare Prospective Payment System will be required to maintain separate cost accounting records, and to file separate cost reports annually utilizing the applicable Medicare cost reporting forms (HCFA 2552 series) and the Medicaid forms (MAP-783 series).

A new facility shall have an interim rate determined using a pro forma cost report or detailed budget prepared by the provider and accepted by the DMAS, which represents its anticipated allowable cost for the first cost reporting period of participation. For the first cost reporting period, the provider will be held to the lesser of its actual operating cost or its peer group ceiling. Subsequent rates will be determined in accordance with the current Medicaid Prospective Payment System as noted in the preceding paragraph of IX.

X. Item 398 D of the 1987 Appropriation Act (as amended), effective April 8, 1987, eliminated reimbursement of return on equity capital to proprietary providers.

XI. Pursuant to Item 389 E4 of the 1988 Appropriation Act (as amended), effective July 1, 1988, a separate group ceiling for allowable operating costs shall be established for state-owned university teaching hospitals.

XII. Nonenrolled providers.

A. Hospitals that are not enrolled as providers with the Department of Medical Assistance Services (DMAS) which submit claims shall be paid based on the DMAS average reimbursable inpatient cost-to-charge ratio, updated annually, for enrolled hospitals less five percent. The five percent is for the cost of the additional manual processing of the claims. Hospitals that are not enrolled shall submit claims using the required DMAS invoice formats. Such claims must be submitted within 12 months from date of services. A hospital is determined to regularly treat Virginia Medicaid recipients and shall be required by DMAS to enroll if it provides more than 500 days of care to Virginia Medicaid recipients during the hospitals' financial fiscal year. A hospital which is required by DMAS to enroll shall be reimbursed in accordance with the current Medicaid Prospective Payment System as described in the preceding Sections I, II, III, IV, V, VI, VII, VIII, IX, and X. The hospital shall be placed in one of the DMAS peer groupings which most nearly reflects its licensed bed size and location (Section V.(1) above). These hospitals shall be required to maintain separate cost accounting records, and to file separate cost reports annually, utilizing the applicable Medicare cost reporting forms, (HCFA 2552 Series) and the Medicaid forms (MAP-783 Series).

B. A newly enrolled facility shall have an interim rate determined using the provider's most recent filed Medicare cost report or a pro forma cost report or detailed budget prepared by the provider and accepted by DMAS, which represents its anticipated allowable cost for the first cost reporting period of participation. For the first cost reporting period, the provider shall be limited to the lesser of its actual operating costs or its peer group ceiling. Subsequent rates shall be determined in accordance with the current Medicaid Prospective Payment System as noted in the preceding paragraph of XII.A.

C. Once a hospital has obtained the enrolled status, 500 days of care, the hospital must agree to become enrolled as required by DMAS to receive reimbursement. This status shall continue during the entire term of the provider's current Medicare certification and subsequent recertification or until mutually terminated with 30 days written notice by either party. The provider must maintain this enrolled status to receive reimbursement. If an enrolled provider elects to terminate the enrolled agreement, the nonenrolled reimbursement status will not be available to the hospital for future reimbursement, except for emergency care.

D. Prior approval must be received from the DMAS Health Services Review Division when a referral has been made for treatment to be received from a nonenrolled acute care facility (in-state or out-of-state), except in the case of an emergency or because medical resources or supplementary resources are more readily available in another state.

E. Nothing in this regulation is intended to preclude DMAS from reimbursing for special services, such as rehabilitation, ventilator, and transplantation, on an exception basis and reimbursing for these services on an individually, negotiated rate basis.

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Title of Regulation: **State Plan for Medical Assistance Relating to Fee-for-Service Reimbursement for Home Health Services.**
VR 460-02-4.1920. Methods and Standards for Establishing Payment Rates - Other Types of Care.
VR 460-03-4.1923. Establishment of Rate Per Visit.

Statutory Authority: § 32.1-325 of the Code of Virginia.

Effective Date: July 1, 1992.

Summary:

The purpose of this amendment is to promulgate permanent regulations which change the reimbursement methodology for home health services to fee-based rather than cost-reimbursed.

The section of the State Plan affected by this action is Attachment 4.19 B, Methods and Standards for Establishing Payment Rates–Other Types of Care. Home health services are provided by certified and licensed home health agencies (HHAs) on a part-time or intermittent basis to recipients in their residences (a recipient's residence may not be a hospital or a nursing home).

Effective January 1, 1991, DMAS implemented utilization control and preauthorization procedures for home health services. These procedures were designed to prevent unnecessary use of services and to ensure that rendered care meets established written criteria and quality standards. On July 1, 1991, DMAS implemented by emergency regulation, a fee-based reimbursement system for home health services to ensure that efficiencies reflected in the new service utilization methodology were fully integrated with corresponding efficiencies in the reimbursement methodology. The final regulations promulgated in this package reflect relatively minor changes to the proposed regulations in response to public comment and agency experience with the emergency regulations.

The reimbursement methodology reimburses HHAs at a flat rate per level of visit for each type of service rendered (licensed nursing, physical therapy, occupational therapy, speech-language pathology services, and home health aide services). In addition, it establishes specific rates for medical equipment and supplies left in the home, and for "extraordinary" transportation costs. Payment rates must not exceed the provider's charges (charge to the general public)

or the Medicare rate, whichever is less.

The methodology also establishes a flat rate for each level of service for those HHAs situated in one of three peer groups. These peer groups are determined by the geographic location of the HHAs operating office and are classified as: URBAN, RURAL, or NORTHERN VIRGINIA. The use of the Health Care Financing Administration (HCFA) designation of urban metropolitan statistical areas (MSAs) is incorporated in determining the appropriate peer group for these classifications.

A separate peer grouping is established within each peer group to distinguish between freestanding and hospital-based HHAs. This accounts for the higher costs of hospital-based agencies resulting from Medicare cost allocation requirements. The Department of Health's (DOH) agencies are established in a separate peer group due to their unique cost characteristics (only one consolidated cost report is filed for all DOH agencies). Rates are calculated as follows:

a. Each HHA is placed in its appropriate peer group.

b. HHAs' Medicaid cost per visit (exclusive of medical supplies costs) is obtained from the 1989 cost-settled Medicaid cost reports. Costs are inflated to a common point in time (June 30, 1991) by using the percent of change in the moving average factor from the Data Resources, Inc. (DRI) National Tables, Market Basket Index of Operating Costs for Home Health Agencies.

c. HHAs per visit costs weighted by the number of Medicaid visits per discipline are ranked and a median determined for each peer group.

d. The fee schedule is adjusted annually on or about January 1, based on the DRI-National HHA forecast factor for the change in the moving average.

Billable durable medical equipment (DME) and supplies, defined as equipment and supplies remaining in the home beyond the time of the visit, will be reimbursed separately. To bill for DME, the agency must also be enrolled as a DME vendor.

Extraordinary transportation costs to and from the recipient's home may be recovered by the home health agency if the recipient resides outside of a 15-mile radius of the home health agency's operating office. Payment is set at a rate per mile as established by the General Services Administration in the Federal Travel Regulations, which are published in the Federal Register, times the excess mileage over the 15-mile radius. If a visit is within the 15-mile radius, the transportation cost is included in the visit rate; therefore, no additional reimbursement for transportation will be made. In order for a home health agency to receive reimbursement for transportation, the recipient must be receiving Medicaid home health services.

Home health agencies were required to file a "Final Medicaid Cost Report" to allow DMAS to cost-settle providers' methodology through June 30, 1991. Effective July 1, 1991, HHAs will be paid at rates established as outlined above.

The implementation of this reimbursement methodology requires billing changes and a change in the MMIS system. Each provider will have separate payment rates based upon peer group, geographic locality, and categories of visits (such as assessment visit, follow-up visit, or comprehensive care).

VR 460-02-4-1920. Methods and Standards for Establishing Payment Rates - Other Types of Care.

The policy and the method to be used in establishing payment rates for each type of care or service (other than inpatient hospitalization, skilled nursing and intermediate care facilities) listed in § 1905(a) of the Social Security Act and included in this State Plan for Medical Assistance are described in the following paragraphs:

a. Reimbursement and payment criteria will be established which are designed to enlist participation of a sufficient number of providers of services in the program so that eligible persons can receive the medical care and services included in the Plan at least to the extent these are available to the general population.

b. Participation in the program will be limited to providers of services who accept, as payment in full, the state's payment plus any copayment required under the State Plan.

c. Payment for care or service will not exceed the amounts indicated to be reimbursed in accord with the policy and methods described in this Plan and payments will not be made in excess of the upper limits described in 42 CFR 447.304(a). The state agency has continuing access to data identifying the maximum charges allowed: such data will be made available to the Secretary, HHS, upon request.

d. Payments for services listed below shall be on the basis of reasonable cost following the standards and principles applicable to the Title XVIII Program. 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.

Reasonable costs will be determined from the filing of a uniform cost report by participating providers. The cost reports are due not later than 90 days after the provider's fiscal year end. If a complete cost report is not received within 90 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 which 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.

Item 398 D of the 1987 Appropriation Act (as amended), effective April 8, 1987, eliminated reimbursement of return on equity capital to proprietary providers.

The services that are cost reimbursed are:

(1) Inpatient hospital services to persons over 65 years of age in tuberculosis and mental disease hospitals

~~(2) Home health care services~~

~~(3)~~ *(2)* Outpatient hospital services excluding laboratory

~~(4)~~ *(3)* Rural health clinic services provided by rural health clinics or other federally qualified health centers defined as eligible to receive grants under the Public Health Services Act §§ 329, 330, and 340.

~~(5)~~ *(4)* Rehabilitation agencies

~~(6)~~ *(5)* Comprehensive outpatient rehabilitation facilities

~~(7)~~ *(6)* Rehabilitation hospital outpatient services.

e. Fee-for-service providers.

(1) Payment for the following services shall be the lowest of: State agency fee schedule, actual charge (charge to the general public), or Medicare (Title XVIII) allowances:

(a) Physicians' services (Supplement 1 has obstetric/pediatric fees.)

(b) Dentists' services

(c) Mental health services including:

Community mental health services

Services of a licensed clinical psychologist

Mental health services provided by a physician

(d) Podiatry

(e) Nurse-midwife services

(f) Durable medical equipment

(g) Local health services

(h) Laboratory services (Other than inpatient hospital)

(i) Payments to physicians who handle laboratory specimens, but do not perform laboratory analysis (limited to payment for handling)

(j) X-Ray services

(k) Optometry services

(l) Medical supplies and equipment.

(m) 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 Supplement 3.

(2) Hospice services payments must be no lower than the amounts using the same methodology used under part A of Title XVIII, and adjusted to disregard offsets attributable to Medicare coinsurance amounts.

f. Payment for pharmacy services shall be the lowest of items (1) through (5) (except that items (1) and (2) will not apply when prescriptions are certified as brand necessary by the prescribing physician in accordance with the procedures set forth in 42 CFR 447.331 (c) if the brand cost is greater than the HCFA upper limit of VMAC cost) subject to the conditions, where applicable, set forth in items (6) and (7) below:

(1) The upper limit established by the Health Care Financing Administration (HCFA) for multiple source

drugs pursuant to 42 CFR §§ 447.331 and 447.332, as determined by the HCFA 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 Virginia Maximum Allowable Cost (VMAC) established by the agency plus a dispensing fee, if a legend drug, for multiple source drugs listed on the VVF.

(3) The Estimated Acquisition Cost (EAC) which shall be based on the published Average Wholesale Price (AWP) minus a percent discount established by the methodology set out in (a) through (c) below. (Pursuant to OBRA 90 § 4401, from January 1, 1991, through December 31, 1994, no changes in reimbursement limits or dispensing fees shall be made which reduce such limits or fees for covered outpatient drugs).

(a) Percent 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, but no less frequently than triennially.

(4) A mark-up allowance (150%) of the Estimated Acquisition Cost (EAC) for covered nonlegend drugs and oral contraceptives.

(5) The provider's usual and customary charge to the public, as identified by the claim charge.

(6) Payment for pharmacy services will be as described above; however, payments for legend drugs (except oral contraceptives) will include the allowed cost of the drug plus only one dispensing fee per month for each specific drug. Payments will be reduced by the amount of the established copayment per prescription by noninstitutionalized clients with exceptions as provided in federal law and regulation.

(7) The Program recognizes the unit dose delivery system of dispensing drugs only for patients residing in nursing facilities. Reimbursements are based on the allowed payments described above plus the unit dose add on fee and an allowance for the cost of unit dose packaging established by the state agency. The maximum allowed drug cost for specific multiple source drugs will be the lesser of: either the VMAC based on the 60th percentile cost level identified by the state agency or HCFA's upper limits. All other drugs will be reimbursed at drug costs not to exceed the estimated acquisition cost determined by the state agency.

(8) Historical determination of EAC. Determination of EAC was the result of an analysis of FY'89 paid claims data of ingredient cost used to develop a matrix of cost using 0 to 10% reductions from AWP as well as discussions with pharmacy providers. As a result of this analysis, AWP minus 9.0% was determined to represent prices currently paid by providers effective October 1, 1990.

The same methodology used to determine AWP minus 9.0% was utilized to determine a dispensing fee of $4.40 per prescription as of October 1, 1990. A periodic review of dispensing fee using Employment Cost Index - wages and salaries, professional and technical workers will be done with changes made in dispensing fee when appropriate. As of October 1, 1990, the Estimated Acquisition Cost will be AWP minus 9.0% and dispensing fee will be $4.40.

g. All reasonable measures will be taken to ascertain the legal liability of third parties to pay for authorized care and services provided to eligible recipients including those measures specified under 42 USC 1396(a)(25).

h. The single state agency will take whatever measures are necessary to assure appropriate audit of records whenever reimbursement is based on costs of providing care and services, or on a fee-for-service plus cost of materials.

i. Payment for transportation services shall be according to the following table:

TYPE OF SERVICE	PAYMENT METHODOLOGY
Taxi services	Rate set by the single state agency
Wheelchair van	Rate set by the single state agency
Nonemergency ambulance	Rate set by the single state agency
Emergency ambulance	Rate set by the single state agency
Volunteer drivers	Rate set by the single state agency
Air ambulance	Rate set by the single state agency
Mass transit	Rate charged to the public
Transportation agreements	Rate set by the single state agency
Special Emergency transportation	Rate set by the single state agency

j. Payments for Medicare coinsurance and deductibles for noninstitutional services shall not exceed the allowed charges determined by Medicare in accordance with 42

CFR 447.304(b) less the portion paid by Medicare, other third party payors, and recipient copayment requirements of this Plan. See Supplement 2 for this methodology.

k. Payment for eyeglasses shall be the actual cost of the frames and lenses not to exceed limits set by the single state agency, plus a dispensing fee not to exceed limits set by the single state agency.

l. Expanded prenatal care services to include patient education, homemaker, and nutritional services shall be reimbursed at the lowest of: state agency fee schedule, actual charge, or Medicare (Title XVIII) allowances.

m. Targeted case management for high-risk pregnant women and infants up to age 1 shall be reimbursed at the lowest of: state agency fee schedule, actual charge, or Medicare (Title XVIII) allowances.

n. Reimbursement for all other nonenrolled institutional and noninstitutional providers.

(1) All other nonenrolled providers shall be reimbursed the lesser of the charges submitted, the DMAS cost to charge ratio, or the Medicare limits for the services provided.

(2) Outpatient hospitals that are not enrolled as providers with the Department of Medical Assistance Services (DMAS) which submit claims shall be paid based on the DMAS average reimbursable outpatient cost-to-charge ratio, updated annually, for enrolled outpatient hospitals less five percent. The five percent is for the cost of the additional manual processing of the claims. Outpatient hospitals that are nonenrolled shall submit claims on DMAS invoices.

(3) Nonenrolled providers of noninstitutional services shall be paid on the same basis as enrolled in-state providers of noninstitutional services. Nonenrolled providers of physician, dental, podiatry, optometry, and clinical psychology services, etc., shall be reimbursed the lesser of the charges submitted, or the DMAS rates for the services.

(4) All nonenrolled noninstitutional providers shall be reviewed every two years for the number of Medicaid recipients they have served. Those providers who have had no claims submitted in the past twelve months shall be declared inactive.

(5) Nothing in this regulation is intended to preclude DMAS from reimbursing for special services, such as rehabilitation, ventilator, and transplantation, on an exception basis and reimbursing for these services on an individually, negotiated rate basis.

o. Refund of overpayments.

(1) Providers reimbursed on the basis of a fee plus cost of materials.

(a) When DMAS determines an overpayment has been made to a provider, DMAS shall promptly send the first demand letter requesting a lump sum refund. Recovery shall be undertaken even though the provider disputes in whole or in part DMAS's determination of the overpayment.

(b) If the provider cannot refund the total amount of the overpayment within 30 days after receiving the DMAS demand letter, the provider shall promptly request an extended repayment schedule.

DMAS may establish a repayment schedule of up to 12 months to recover all or part of an overpayment or, if a provider demonstrates that repayment within a 12-month period would create severe financial hardship, the Director of the Department of Medical Assistance Services (the "director") may approve a repayment schedule of up to 36 months.

A provider shall have no more than one extended repayment schedule in place at one time. If an audit later uncovers an additional overpayment, the full amount shall be repaid within 30 days unless the provider submits further documentation supporting a modification to the existing extended repayment schedule to include the additional amount.

If, during the time an extended repayment schedule is in effect, the provider withdraws from the Program, the outstanding balance shall become immediately due and payable.

When a repayment schedule is used to recover only part of an overpayment, the remaining amount shall be recovered by the reduction of interim payments to the provider or by lump sum payments.

(c) In the request for an extended repayment schedule, the provider shall document the need for an extended (beyond 30 days) repayment and submit a written proposal scheduling the dates and amounts of repayments. If DMAS approves the schedule, DMAS shall send the provider written notification of the approved repayment schedule, which shall be effective retroactive to the date the provider submitted the proposal.

(d) Once an initial determination of overpayment has been made, DMAS shall undertake full recovery of such overpayment whether the provider disputes, in whole or in part, the initial determination of overpayment. If an appeal follows, interest shall be waived during the period of administrative appeal of an initial determination of overpayment.

Interest charges on the unpaid balance of any

overpayment shall accrue pursuant to § 32.1-313 of the Code of Virginia from the date the director's determination becomes final.

The director's determination shall be deemed to be final on (i) the issue date of any notice of overpayment, issued by DMAS, if the provider does not file an appeal, or (ii) the issue date factfinding conference, if the provider does not file an appeal, or (iii) the issue date of any administrative decision signed by the director, regardless of whether a judicial appeal follows. In any event, interest shall be waived if the overpayment is completely liquidated within 30 days of the date of the final determination. In cases in which a determination of overpayment has been judicially reversed, the provider shall be reimbursed that portion of the payment to which it is entitled, plus any applicable interest which the provider paid to DMAS.

(2) Providers reimbursed on the basis of reasonable costs.

(a) When the provider files a cost report indicating that an overpayment has occurred, full refund shall be remitted with the cost report. In cases where DMAS discovers an overpayment during desk review, field audit, or final settlement, DMAS shall promptly send the first demand letter requesting a lump sum refund. Recovery shall be undertaken even though the provider disputes in whole or in part DMAS's determination of the overpayment.

(b) If the provider has been overpaid for a particular fiscal year and has been underpaid for another fiscal year, the underpayment shall be offset against the overpayment. So long as the provider has an overpayment balance, any underpayments discovered by subsequent review or audit shall also be used to reduce the remaining amount of the overpayment.

(c) If the provider cannot refund the total amount of the overpayment (i) at the time it files a cost report indicating that an overpayment has occurred, the provider shall request an extended repayment schedule at the time of filing, or (ii) within 30 days after receiving the DMAS demand letter, the provider shall promptly request an extended repayment schedule.

DMAS may establish a repayment schedule of up to 12 months to recover all or part of an overpayment or, if a provider demonstrates that repayment within a 12-month period would create severe financial hardship, the Director of the Department of Medical Assistance Services (the "director") may approve a repayment schedule of up to 36 months.

A provider shall have no more than one extended repayment schedule in place at one time. If an audit later uncovers an additional overpayment, the full amount shall be repaid within 30 days unless the provider submits further documentation supporting a modification to the existing extended repayment schedule to include the additional amount.

If, during the time an extended repayment schedule is in effect, the provider withdraws from the Program or fails to file a cost report in a timely manner, the outstanding balance shall become immediately due and payable.

When a repayment schedule is used to recover only part of an overpayment, the remaining amount shall be recovered by the reduction of interim payments to the provider or by lump sum payments.

(d) In the request for an extended repayment schedule, the provider shall document the need for an extended (beyond 30 days) repayment and submit a written proposal scheduling the dates and amounts of repayments. If DMAS approves the schedule, DMAS shall send the provider written notification of the approved repayment schedule, which shall be effective retroactive to the date the provider submitted the proposal.

(e) Once an initial determination of overpayment has been made, DMAS shall undertake full recovery of such overpayment whether or not the provider disputes, in whole or in part, the initial determination of overpayment. If an appeal follows, interest shall be waived during the period of administrative appeal of an initial determination of overpayment.

Interest charges on the unpaid balance of any overpayment shall accrue pursuant to § 32.1-313 of the Code of Virginia from the date the director's determination becomes final.

The director's determination shall be deemed to be final on (i) the due date of any cost report filed by the provider indicating that an overpayment has occurred, or (ii) the issue date of any notice of overpayment, issued by DMAS, if the provider does not file an appeal, or (iii) the issue date of any administrative decision issued by DMAS after an informal factfinding conference, if the provider does not file an appeal, or (iv) the issue date of any administrative decision signed by the director, regardless of whether a judicial appeal follows. In any event, interest shall be waived if the overpayment is completely liquidated within 30 days of the date of the final determination. In cases in which a determination of overpayment has been judicially reversed, the provider shall be reimbursed that portion of the payment to which it is entitled, plus any applicable interest which the provider paid to DMAS.

VR 460-03-4.1923. Establishment of Rate Per Visit.

§ 1. Effective for dates of services on and after July 1, 1991, the Department of Medical Assistance Services (DMAS) shall reimburse home health agencies (HHAs) at a flat rate per visit for each type of service rendered by HHAs (i.e., nursing, physical therapy, occupational therapy, speech-language pathology services, and home health aide services.) In addition, supplies left in the home and extraordinary transportation costs will be paid at specific rates.

§ 2. DMAS shall establish a flat rate for each level of service for HHAs located in three peer groups. These peer groups shall be determined by the geographic location of the HHA's operating office and shall be classified as: URBAN, RURAL, or NORTHERN VIRGINIA. The use of the Health Care Financing Administration (HCFA) designation of urban metropolitan statistical areas (MSAs) shall be incorporated in determining the appropriate peer group for these classifications.

§ 3. A separate grouping shall be established within each of the three peer groups to distinguish between freestanding and hospital-based HHAs. This shall account for the higher costs of hospital-based agencies resulting from Medicare cost allocation requirements. The Department of Health's agencies shall be established in another peer group due to their unique cost characteristics (only one consolidated cost report is filed for all Department of Health agencies). Rates shall be calculated as follows:

1. Each home health agency shall be placed in its appropriate peer group.

2. Home health agencies' Medicaid cost per visit (exclusive of medical supplies costs) shall be obtained from the 1989 cost-settled Medicaid Cost Reports. Costs shall be inflated to a common point in time (June 30, 1991) by using the percent of change in the moving average factor of the Data Resources, Inc. (DRI), National Forecast Tables for the Home Health Agency Market Basket.

3. To determine the flat rate per visit effective July 1, 1991, the following methodology shall be utilized.

a. Each HHA's per visit rate shall be normalized for those peer groups that have different wage indexes as determined by Medicare for the MSAs in Virginia.

b. The normalized HHA peer group rates and visits shall be adjusted to remove any HHA per visit rates that are outside of plus or minus one standard deviation from the peer group mean to eliminate any data that might distort the median rate per visit determination.

c. The peer group HHA's per visit rates shall be ranked and weighted by the number of Medicaid visits per discipline to determine a median rate per visit for each peer group at July 1, 1991.

d. The HHA's rate effective July 1, 1991, shall be the lower of the peer group median or the Medicare upper limit per visit for each discipline.

e. Separate rates shall be provided for the initial assessment, follow-up, and comprehensive visits for skilled nursing and for the initial assessment and follow-up visits for physical therapy, occupational therapy, and speech therapy. The comprehensive rate shall be 200% of the follow-up rate, and the initial assessment rates shall be $15 higher than the follow-up rates. The lower of the peer group median or Medicare upper limits shall be adjusted as appropriate to assure budget neutrality when the higher rates for the comprehensive and initial assessment visits are calculated.

4. The fee schedule shall be adjusted annually on or about January 1, based on the percent of change in the moving average of Data Resources, Inc., National Forecast Tables for the Home Health Agency Market Basket determined in the third quarter of the previous calendar year. The method to calculate the annual update shall be:

a. The HHA's peer group rate effective July 1, 1991, shall become the final peer group rate for the first partial year ending December 31, 1991, and shall be the interim peer group rate for calculating the update January 1, 1992. [~~*The interim peer group rate at January 1, 1992, shall be updated for 100% of historical inflation from July 1, 1991, through December 31, 1991, and*~~ *For all HHA peer groups the interim peer group rate shall be updated for 100% of historical inflation from July 1, 1991, through December 31, 1991, and shall become the final interim peer group rate which shall be updated by*] *50% of the forecasted inflation to the end of December 31, 1992, to establish the final peer group rate.* [*The lower of the final peer group rates or the Medicare upper limit at January 1, 1992, will be effective for payments from January 1, 1992, through December 31, 1992.*

There will be a one time adjustment made for those HHA final peer group rates that were established at July 1, 1991, based on the Medicare upper limits. The peer group median and the Medicare upper limit at July 1, 1991, shall be updated by 100% of historical inflation from July 1, 1991, through December 31, 1991. The final interim peer group rate shall be the lower of the two which shall be updated by 50% of the forecasted inflation to the end of December 31, 1992, to establish the final peer group. For these peer groups the lower of the final peer group rate or the Medicare upper limit at January 1, 1992, will be effective from July 1, 1992,

through December 31, 1992.]

b. All subsequent year peer group rates shall be calculated utilizing this same method with the previous final [*interim*] *peer group rate established on January 1 becoming the interim peer group rate at December 31 each year. The interim peer group rate shall be updated for 100% of historical inflation for the previous twelve months, January 1 through December 31, and* [*shall become the final interim peer group rate which shall be updated by*] *50% of the forecasted inflation for the subsequent 12 months, January 1 through December 31.*

c. The annual update shall be compared to the Medicare upper limit per visit in effect on each January 1, and the HHA's shall receive the lower of the annual update or the Medicare upper limit per visit as the [*final*] *peer group rate.*

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Title of Regulation: **State Plan for Medical Assistance Relating to Community Mental Health/Mental Retardation Services.**
VR 460-03-3.1100. Amount, Duration and Scope of Services.
VR 460-03-3.1102. Case Management Services.
VR 460-02-3.1300. Standards Established and Methods Used to Assure High Quality Care.
VR 460-02-4.1920. Methods and Standards for Establishing Payment Rates–Other Types of Care.
VR 460-04-8.1500. Community Mental Health and Mental Retardation Services: Amount, Duration and Scope of Services.

Statutory Authority: § 32.1-325 of the Code of Virginia.

Effective Date: July 1, 1992.

Summary:

This amendment governs rehabilitative services for persons with mental illness or mental retardation.

The 1990 Appropriations Act (Item 466) directed the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) and DMAS to provide Medicaid coverage for community mental health and mental retardation services in Virginia. The purpose of this expansion of the Medicaid program is to obtain federal financial participation for some current programs and services as well as to meet future demand for treatment services. At a time of increasing fiscal constraints on state dollars, federal funding through Title XIX is the only mechanism available for addressing significant unmet service needs and continuing the Phase I Community Services initiative. In addition, this action enables the Commonwealth to make effective use of federal funds.

On October 1, 1990, Medicaid began coverage of mental health, mental retardation rehabilitation services under an emergency regulation. During subsequent months, the DMAS and DMHMRSAS received feedback and resolved implementation problems associated with the emergency regulation, as identified by the Community Services Boards (CSBs). Some of the regulation's provisions presented implementation problems which could only be resolved by substantive change to the regulation itself. Thus a second emergency regulation was implemented effective July 1, 1991.

The second emergency regulation differed from the initial regulation by including provisions proposed by the CSBs to simplify regulatory requirements imposed on the Boards, and to increase the services for which Medicaid reimbursement can be made. This final regulation reflects the content of the second emergency regulation and changes made to reflect public comments received.

The scope and coverage of this final regulation include Medicaid options for mental health and mental retardation services. The service definitions, provider requirements and qualification, and utilization review requirements included in the Plan change were developed by a task force of DMAS, DMHMRSAS, and local Community Services Board representatives.

Covered mental health services include targeted case management and rehabilitation services (e.g., emergency services, partial hospitalization/day treatment for adults, psychosocial rehabilitation for adults, therapeutic day treatment for children and adolescents).

For patients to be eligible to receive community mental health services, they must meet the standard Medicaid eligibility criteria. In addition, other service-specific criteria include the following: mental health targeted case management services will be limited to adults with serious mental illness and children with serious emotional disturbances or who are at risk for serious emotional disturbance, as determined by diagnosis, level of disability, and duration of illness; eligibility for mental health rehabilitation services will be determined by specific utilization criteria.

Covered mental retardation services include targeted case management and rehabilitation services such as day health and rehabilitation services.

Targeted case management services will be directed to those Medicaid eligibles who are mentally retarded. All of the mental retardation services will be provided based on a plan of care, developed by the case manager, which is to be approved and reviewed by DMHMRSAS staff every six months. Eligibility for

mental retardation services will be determined by specific utilization criteria.

The 1988-90 Appropriations Act specifically dictated controls upon the providers who would be eligible to provide these services. These new covered services will be limited to providers who meet the specified qualifications. Programs must:

- *Be in accordance with the DMHMRSAS Comprehensive State Plan, 1990-96*
- *Be licensed under regulations promulgated by DMHMRSAS*
- *Guarantee client access to emergency services on a 24-hour basis*
- *Demonstrate willingness and ability to serve all in need, regardless of ability to pay, or eligibility for Medicaid*
- *Have the necessary administrative and financial management capabilities*
- *Have the capacity to document individual case records to meet state and federal requirements.*

VR 460-03-3.1100. Amount, Duration and Scope of Services.

General.

The provision of the following services cannot be reimbursed except when they are ordered or prescribed, and directed or performed within the scope of the license of a practitioner of the healing arts: laboratory and x-ray services, family planning services, and home health services. Physical therapy services will be reimbursed only when prescribed by a physician.

§ 1. Inpatient hospital services other than those provided in an institution for mental diseases.

A. Medicaid inpatient hospital admissions (lengths-of-stay) are limited to the 75th percentile of PAS (Professional Activity Study of the Commission on Professional and Hospital Activities) diagnostic/procedure limits. For admissions under 15 days that exceed the 75th percentile, the hospital must attach medical justification records to the billing invoice to be considered for additional coverage when medically justified. For all admissions that exceed 14 days up to a maximum of 21 days, the hospital must attach medical justification records to the billing invoice. (See the exception to subsection F of this section.)

B. Medicaid does not pay the medicare (Title XVIII) coinsurance for hospital care after 21 days regardless of the length-of-stay covered by the other insurance. (See exception to subsection F of this section.)

C. Reimbursement for induced abortions is provided in only those cases in which there would be a substantial endangerment to health or life of the mother if the fetus were carried to term.

D. Reimbursement for covered hospital days is limited to one day prior to surgery, unless medically justified. Hospital claims with an admission date more than one day prior to the first surgical date will pend for review by medical staff to determine appropriate medical justification. The hospital must write on or attach the justification to the billing invoice for consideration of reimbursement for additional preoperative days. Medically justified situations are those where appropriate medical care cannot be obtained except in an acute hospital setting thereby warranting hospital admission. Medically unjustified days in such admissions will be denied.

E. Reimbursement will not be provided for weekend (Friday/Saturday) admissions, unless medically justified. Hospital claims with admission dates on Friday or Saturday will be pended for review by medical staff to determine appropriate medical justification for these days. The hospital must write on or attach the justification to the billing invoice for consideration of reimbursement coverage for these days. Medically justified situations are those where appropriate medical care cannot be obtained except in an acute hospital setting thereby warranting hospital admission. Medically unjustified days in such admissions will be denied.

F. Coverage of inpatient hospitalization will be limited to a total of 21 days for all admissions within a fixed period, which would begin with the first day inpatient hospital services are furnished to an eligible recipient and end 60 days from the day of the first admission. There may be multiple admissions during this 60-day period; however, when total days exceed 21, all subsequent claims will be reviewed. Claims which exceed 21 days within 60 days with a different diagnosis and medical justification will be paid. Any claim which has the same or similar diagnosis will be denied.

EXCEPTION: SPECIAL PROVISIONS FOR ELIGIBLE INDIVIDUALS UNDER 21 YEARS OF AGE: Consistent with 42 CFR 441.57, 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 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. Medical documentation justifying admission and the continued length of stay must be attached to or written on the invoice for review by medical staff to determine medical necessity. Medically unjustified days in such admissions will be denied.

G. Repealed.

H. Reimbursement will not be provided for inpatient

hospitalization for those surgical and diagnostic procedures listed on the mandatory outpatient surgery list unless the inpatient stay is medically justified or meets one of the exceptions. The requirements for mandatory outpatient surgery do not apply to recipients in the retroactive eligibility period.

I. For the purposes of organ transplantation, all similarly situated individuals will be treated alike. Coverage of transplant services for all eligible persons is limited to transplants for kidneys and corneas. Kidney transplants require preauthorization. Cornea transplants do not require preauthorization. The patient must be considered acceptable for coverage and treatment. The treating facility and transplant staff must be recognized as being capable of providing high quality care in the performance of the requested transplant. The amount of reimbursement for covered kidney transplant services is negotiable with the providers on an individual case basis. Reimbursement for covered cornea transplants is at the allowed Medicaid rate. Standards for coverage of organ transplant services are in Attachment 3.1 E.

J. The department may exempt portions or all of the utilization review documentation requirements of subsections A, D, E, F as it pertains to recipients under age 21, G, or H in writing for specific hospitals from time to time as part of their ongoing hospital utilization review peformance evaluation. These exemptions are based on utilization review performance and review edit criteria which determine an individual hospital's review status as specified in the hospital provider manual. In compliance with federal regulations at 42 CFR 441.200, Subparts E and F, claims for hospitalization in which sterlization, hysterectomy or abortion procedures were performed, shall be subject to medical documentation requirements.

K. Hospitals qualifying for an exemption of all documentation requirements except as described in subsection J above shall be granted "delegated review status" and shall, while the exemption remains in effect, not be required to submit medical documentation to support pended claims on a prepayment hospital utilzation review basis to the extent allowed by federal or state law or regulation. The following audit conditions apply to delegated review status for hospitals:

1. The department shall conduct periodic on-site post-payment audits of qualifying hospitals using a statistically valid sampling of paid claims for the purpose of reviewing the medical necessity of inpatient stays.

2. The hospital shall make all medical records of which medical reviews will be necessary available upon request, and shall provide an appropriate place for the department's auditors to conduct such review.

3. The qualifying hospital will immediately refund to the department in accordance with § 32.1-325.1 A and B of the Code of Virginia the full amount of any initial overpayment identified during such audit.

4. The hospital may appeal adverse medical necessity and overpayment decisions pursuant to the current administrative process for appeals of post-payment review decisions.

5. The department may, at its option, depending on the utilization review performance determined by an audit based on criteria set forth in the hospital provider manual, remove a hospital from delegated review status and reapply certain or all prepayment utilization review documentation requirements.

§ 2. Outpatient hospital and rural health clinic services.

2a. Outpatient hospital services.

1. Outpatient hospital services means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that:

a. Are furnished to outpatients;

b. Except in the case of nurse-midwife services, as specified in § 440.165, are furnished by or under the direction of a physician or dentist; and

c. Are furnished by an institution that:

(1) Is licensed or formally approved as a hospital by an officially designated authority for state standard-setting; and

(2) Except in the case of medical supervision of nurse-midwife services, as specified in § 440.165, meets the requirements for participation in Medicare.

2. Reimbursement for induced abortions is provided in only those cases in which there would be substantial endangerment of health or life to the mother if the fetus were carried to term.

3. Reimbursement will not be provided for outpatient hospital services for any selected elective surgical procedures that require a second surgical opinion unless a properly executed second surgical opinion form has been obtained from the physician and submitted with the invoice for payment, or is a justified emergency or exemption.

2b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.

The same service limitations apply to rural health clinics as to all other services.

2c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with § 4231

of the State Medicaid Manual (HCFA Pub. 45-4).

The same service limitations apply to FQHCs as to all other services.

§ 3. Other laboratory and x-ray services.

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

§ 4. Skilled nursing facility services, EPSDT and family planning.

4a. 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.

4b. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.

1. Consistent with 42 CFR 441.57, 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.

4c. Family planning services and supplies for individuals of child-bearing age.

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

§ 5. Physician's services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere.

A. Elective surgery as defined by the Program is surgery that is not medically necessary to restore or materially improve a body function.

B. Cosmetic surgical procedures are not covered unless performed for physiological reasons and require Program prior approval.

C. Routine physicals and immunizations are not covered except when the services are provided under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program and when a well-child examination is performed in a private physician's office for a foster child of the local social services department on specific referral from those departments.

D. Psychiatric services are limited to an initial availability of 26 sessions, with one possible extension (subject to the approval of the Psychiatric Review Board) of 26 sessions during the first year of treatment. The availability is further restricted to no more than 26 sessions each succeeding year when approved by the Psychiatric Review Board. Psychiatric services are further restricted to no more than three sessions in any given seven-day period. These limitations also apply to psychotherapy sessions by clinical psychologists licensed by the State Board of Medicine and psychologists clinical licensed by the Board of Psychology.

E. Any procedure considered experimental is not covered.

F. Reimbursement for induced abortions is provided in only those cases in which there would be a substantial endangerment of health or life to the mother if the fetus were carried to term.

G. Physician visits to inpatient hospital patients are limited to a maximum of 21 days per admission within 60 days for the same or similar diagnoses and is further restricted to medically necessary inpatient hospital days as determined by the Program.

EXCEPTION: SPECIAL PROVISIONS FOR ELIGIBLE INDIVIDUALS UNDER 21 YEARS OF AGE: Consistent with 42 CFR 441.57, 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 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. Payments for physician visits for inpatient days determined to be medically unjustified will be adjusted.

H. Psychological testing and psychotherapy by clinical psychologists licensed by the State Board of Medicine and psychologists clinical licensed by the Board of Psychology are covered.

I. Repealed.

J. Reimbursement will not be provided for physician services performed in the inpatient setting for those surgical or diagnostic procedures listed on the mandatory outpatient surgery list unless the service is medically justified or meets one of the exceptions. The requirements of mandatory outpatient surgery do not apply to recipients in a retroactive eligibility period.

K. For the purposes of organ transplantation, all similarly situated individuals will be treated alike. Coverage of transplant services for all eligible persons is limited to transplants for kidneys and corneas. Kidney transplants require preauthorization. Cornea transplants do not require preauthorization. The patient must be considered acceptable for coverage and treatment. The treating facility and transplant staff must be recognized as being capable of providing high quality care in the performance of the requested transplant. The amount of reimbursement for covered kidney transplant services is negotiable with the providers on an individual case basis. Reimbursement for covered cornea transplants is at the allowed Medicaid rate. Standards for coverage of organ transplant services are in Attachment 3.1 E.

§ 6. Medical care by other licensed practitioners within the scope of their practice as defined by state law.

A. Podiatrists' services.

1. Covered podiatry services are defined as reasonable and necessary diagnostic, medical, or surgical treatment of disease, injury, or defects of the human foot. These services must be within the scope of the license of the podiatrists' profession and defined by state law.

2. The following services are not covered: preventive health care, including routine foot care; treatment of structural misalignment not requiring surgery; cutting or removal of corns, warts, or calluses; experimental procedures; acupuncture.

3. The Program may place appropriate limits on a service based on medical necessity or for utilization control, or both.

B. Optometric services.

1. Diagnostic examination and optometric treatment procedures and services by ophthamologists, optometrists, and opticians, as allowed by the Code of Virginia and by regulations of the Boards of Medicine and Optometry, are covered for all recipients. Routine refractions are limited to once in 24 months except as may be authorized by the agency.

C. Chiropractors' services.

Not provided.

D. Other practitioners' services.

1. Clinical psychologists' services.

a. These limitations apply to psychotherapy sessions by clinical psychologists licensed by the State Board of Medicine and psychologists clinical licensed by the Board of Psychology. Psychiatric services are limited to an initial availability of 26 sessions, with one possible extension of 26 sessions during the first year of treatment. The availability is further restricted to no more than 26 sessions each succeeding year when approved by the Psychiatric Review Board. Psychiatric services are further restricted to no more than three sessions in any given seven-day period.

b. Psychological testing and psychotherapy by clinical psychologists licensed by the State Board of Medicine and psychologists clinical licensed by the Board of Psychology are covered.

§ 7. Home health services.

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

B. Nursing services provided by a home health agency.

1. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.

2. Patients may receive up to 32 visits by a licensed nurse within a 60-day period without authorization. A patient may receive a maximum of 64 nursing visits annually without authorization. If services beyond these limitations are determined by the physician to be required, then the home health agency shall request authorization from DMAS for additional services.

C. Home health aide services provided by a home health agency.

1. Home health aides must function under the supervision of a professional nurse.

2. Home health aides must meet the certification requirements specified in 42 CFR 484.36.

3. For home health aide services, patients may receive up to 32 visits within a 60-day period without authorization from DMAS. A recipient may receive a maximum of 64 visits annually without authorization. If services beyond these limitations are determined by the physician to be required, then the home health agency shall request authorization from DMAS for additional services.

D. Medical supplies, equipment, and appliances suitable for use in the home.

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

2. Medical supplies, equipment, and appliances for all others are limited to home renal dialysis equipment and supplies, respiratory equipment and oxygen, and ostomy supplies, as authorized by the agency.

3. Supplies, equipment, or appliances that are not covered include, but are not limited to, the following:

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

b. Durable medical equipment and supplies for any hospital or nursing facility resident, except ventilators and associated supplies for nursing facility residents that have been approved by DMAS central office.

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

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

e. Prosthesis, except for artificial arms, legs, and their supportive devices which must be preauthorized by the DMAS central office (effective July 1, 1989).

f. Items and services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member (for example, over-the-counter drugs; dentifrices; toilet articles; shampoos which do not require a physician's prescription; dental adhesives; electric toothbrushes; cosmetic items, soaps, and lotions which do not require a physician's prescription; sugar and salt substitutes; support stockings; and nonlegend drugs.

g. Orthotics, including braces, splints, and supports.

h. Home or vehicle modifications.

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

j. Equipment that the primary function is vocationally or educationally related (i.e., computers, environmental control devices, speech devices, etc.).

E. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

1. Service covered only as part of a physician's plan of care.

2. Patients may receive up to 24 visits for each rehabilitative therapy service ordered within a 60-day period without authorization. Patients may receive up to 48 visits for each rehabilitative service ordered annually without authorization. If services beyond these limitations are determined by the physician to be required, then the home health agency shall request authorization from DMAS for additional services.

§ 8. Private duty nursing services.

Not provided.

§ 9. Clinic services.

A. Reimbursement for induced abortions is provided in only those cases in which there would be a substantial endangerment of health or life to the mother if the fetus was carried to term.

B. Clinic services means preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that:

1. Are provided to outpatients;

2. Are provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients; and

3. Except in the case of nurse-midwife services, as specified in 42 dentist.

§ 10. Dental services.

A. Dental services are limited to recipients under 21 years of age in fulfillment of the treatment requirements under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program and defined as routine diagnostic, preventive, or restorative procedures necessary for oral health provided by or under the direct supervision of a dentist in accordance with the State Dental Practice Act.

B. Initial, periodic, and emergency examinations; required radiography necessary to develop a treatment plan; patient education; dental prophylaxis; fluoride treatments; dental sealants; routine amalgam and composite restorations; crown recementation; pulpotomies; emergency endodontics for temporary relief of pain; pulp capping; sedative fillings; therapeutic apical closure; topical palliative treatment for dental pain; removal of foreign body; simple extractions; root recovery; incision and drainage of abscess; surgical exposure of the tooth to aid eruption; sequestrectomy for osteomyelitis; and oral antral fistula closure are dental services covered without preauthorization by the state agency.

C. All covered dental services not referenced above require preauthorization by the state agency. The following services are also covered through preauthorization: medically necessary full banded orthodontics, for handicapping malocclusions, minor tooth guidance or repositioning appliances, complete and partial dentures, surgical preparation (alveoloplasty) for prosthetics, single permanent crowns, and bridges. The following service is not covered: routine bases under restorations.

D. The state agency may place appropriate limits on a service based on medical necessity, for utilization control, or both. Examples of service limitations are: examinations, prophylaxis, fluoride treatment (once/six months); space maintenance appliances; bitewing x-ray – two films (once/12 months); routine amalgam and composite restorations (once/three years); dentures (once per 5 years); extractions, orthodontics, tooth guidance appliances, permanent crowns, and bridges, endodontics, patient education and sealants (once).

E. Limited oral surgery procedures, as defined and covered under Title XVIII (Medicare), are covered for all recipients, and also require preauthorization by the state agency.

§ 11. Physical therapy and related services.

Physical therapy and related services shall be defined as physical therapy, occupational therapy, and speech-language pathology services. These services shall be prescribed by a physician and be part of a written plan of care. Any one of these services may be offered as the sole service and shall not be contingent upon the provision of another service. All practitioners and providers of services shall be required to meet state and federal licensing and/or certification requirements.

11a. Physical Therapy.

A. Services for individuals requiring physical therapy are provided only as an element of hospital inpatient or outpatient service, nursing facility service, home health service, services provided by a local school division employing qualified therapists, or when otherwise included as an authorized service by a cost provider who provides rehabilitation services.

B. Effective July 1, 1988, the Program will not provide direct reimbursement to enrolled providers for physical therapy service rendered to patients residing in long term care facilities. Reimbursement for these services is and continues to be included as a component of the nursing homes' operating cost.

C. Physical therapy services meeting all of the following conditions shall be furnished to patients:

1. Physical therapy services shall be directly and specifically related to an active written care plan designed by a physician after any needed consultation with a physical therapist licensed by the Board of Medicine;

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a physical therapist licensed by the Board of Medicine, or a physical therapy assistant who is licensed by the Board of Medicine and is under the direct supervision of a physical therapist licensed by the Board of Medicine. When physical therapy services are provided by a qualified physical therapy assistant, such services shall be provided under the supervision of a qualified physical therapist who makes an onsite supervisory visit at least once every 30 days. This visit shall not be reimbursable.

3. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services shall be reasonable.

11b. Occupational therapy.

A. Services for individuals requiring occupational therapy are provided only as an element of hospital inpatient or outpatient service, nursing facility service, home health service, services provided by a local school division employing qualified therapists, or when otherwise included as an authorized service by a cost provider who provides rehabilitation services.

B. Effective September 1, 1990, Virginia Medicaid will not make direct reimbursement to providers for occupational therapy services for Medicaid recipients residing in long-term care facilities. Reimbursement for these services is and continues to be included as a component of the nursing facilities' operating cost.

C. Occupational therapy services shall be those services furnished a patient which meet all of the following conditions:

1. Occupational therapy services shall be directly and specifically related to an active written care plan designed by a physician after any needed consultation with an occupational therapist registered and certified by the American Occupational Therapy Certification Board.

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by an occupational therapist registered and certified by the American Occupational Therapy Certification Board, a graduate of a program approved by the Council on Medical Education of the American Medical Association and engaged in the supplemental clinical experience required before registration by the American Occupational Therapy Association when under the supervision of an occupational therapist defined above, or an occupational therapy assistant who is certified by the American Occupational Therapy Certification Board under the direct supervision of an occupational therapist as defined above. When occupational therapy services are provided by a qualified occupational therapy assistant or a graduate engaged in supplemental clinical experience required before registration, such services shall be provided under the supervision of a qualified occupational therapist who makes an onsite supervisory visit at least once every 30 days. This visit shall not be reimbursable.

3. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services shall be reasonable.

11c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist; see Page 1, General and Page 12, Physical Therapy and Related Services.)

A. These services are provided by or under the supervision of a speech pathologist or an audiologist only as an element of hospital inpatient or outpatient service, nursing facility service, home health service, services provided by a local school division employing qualified therapists, or when otherwise included as an authorized service by a cost provider who provides rehabilitation services.

B. Effective September 1, 1990, Virginia Medicaid will not make direct reimbursement to providers for speech-language pathology services for Medicaid recipients residing in long-term care facilities. Reimbursement for these services is and continues to be included as a component of the nursing facilities' operating cost.

C. Speech-language pathology services shall be those services furnished a patient which meet all of the following conditions:

1. The services shall be directly and specifically related to an active written treatment plan designed by a physician after any needed consultation with a speech-language pathologist licensed by the Board of Audiology and Speech Pathology, or, if exempted from licensure by statute, meeting the requirements in 42 CFR 440.110(c);

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by or under the direction of a speech-language pathologist who meets the qualifications in number 1. The program shall meet the requirements of 42 CFR 405.1719(c). At least one qualified speech-language pathologist must be present at all times when speech-language pathology services are rendered; and

3. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services shall be reasonable.

11d. Authorization for services.

A. Physical therapy, occupational therapy, and speech-language pathology services provided in outpatient settings of acute and rehabilitation hospitals, rehabilitation agencies, or home health agencies shall include authorization for up to 24 visits by each ordered rehabilitative service within a 60-day period. A recipient may receive a maximum of 48 visits annually without authorization. The provider shall maintain documentation to justify the need for services.

B. The provider shall request from DMAS authorization for treatments deemed necessary by a physician beyond the number authorized. This request must be signed and dated by a physician. Authorization for extended services shall be based on individual need. Payment shall not be made for additional service unless the extended provision of services has been authorized by DMAS.

11e. Documentation requirements.

A. Documentation of physical therapy, occupational therapy, and speech-language pathology services provided by a hospital-based outpatient setting, home health agency, a school division, or a rehabilitation agency shall, at a minimum:

1. Describe the clinical signs and symptoms of the patient's condition;

2. Include an accurate and complete chronological picture of the patient's clinical course and treatments;

3. Document that a plan of care specifically designed for the patient has been developed based upon a comprehensive assessment of the patient's needs;

4. Include a copy of the physician's orders and plan of care;

5. Include all treatment rendered to the patient in accordance with the plan with specific attention to frequency, duration, modality, response, and identify who provided care (include full name and title);

6. Describe changes in each patient's condition and response to the rehabilitative treatment plan;

7. (Except for school divisions) describe a discharge plan which includes the anticipated improvements in functional levels, the time frames necessary to meet these goals, and the patient's discharge destination; and

8. In school divisions, include an individualized education program (IEP) which describes the anticipated improvements in functional level in each school year and the time frames necessary to meet these goals.

B. Services not specifically documented in the patient's medical record as having been rendered shall be deemed not to have been rendered and no coverage shall be provided.

11f. Service limitations. The following general conditions shall apply to reimbursable physical therapy, occupational therapy, and speech-language pathology:

A. Patient must be under the care of a physician who is legally authorized to practice and who is acting within the scope of his license.

B. Services shall be furnished under a written plan of treatment and must be established and periodically reviewed by a physician. The requested services or items must be necessary to carry out the plan of treatment and must be related to the patient's condition.

C. A physician recertification shall be required periodically, must be signed and dated by the physician who reviews the plan of treatment, and may be obtained when the plan of treatment is reviewed. The physician recertification statement must indicate the continuing need for services and should estimate how long rehabilitative services will be needed.

D. The physician orders for therapy services shall include the specific procedures and modalities to be used, identify the specific discipline to carry out the plan of care, and indicate the frequency and duration for services.

E. Utilization review shall be performed to determine if services are appropriately provided and to ensure that the services provided to Medicaid recipients are medically necessary and appropriate. Services not specifically documented in the patient's medical record as having been rendered shall be deemed not to have been rendered and no coverage shall be provided.

F. Physical therapy, occupational therapy and speech-language services are to be terminated regardless of the approved length of stay when further progress toward the established rehabilitation goal is unlikely or when the services can be provided by someone other than the skilled rehabilitation professional.

§ 12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

12a. Prescribed drugs.

1. Nonlegend drugs, except insulin, syringes, needles, diabetic test strips for clients under 21 years of age, and family planning supplies are not covered by Medicaid. This limitation does not apply to Medicaid recipients who are in skilled and intermediate care facilities.

2. Legend drugs, with the exception of anorexiant drugs prescribed for weight loss and transdermal drug delivery systems, are covered. Coverage of anorexiants for other than weight loss requires preauthorization.

3. The Program will not provide reimbursement for drugs determined by the Food and Drug Administration (FDA) to lack substantial evidence of effectiveness.

4. Notwithstanding the provisions of § 32.1-87 of the Code of Virginia, prescriptions for Medicaid recipients for specific multiple source drugs shall be filled with generic drug products listed in the Virginia Voluntary Formulary unless the physician or other practitioners so licensed and certified to prescribe drugs certifies in his own handwriting "brand necessary" for the prescription to be dispensed as written.

5. New drugs, except for Treatment Investigational New Drugs (Treatment IND), are not covered until approved by the board, unless a physician obtains prior approval. The new drugs listed in Supplement 1 to the New Drug Review Program Regulations (VR 460-05-2000.1000) are not covered.

12b. Dentures.

Provided only as a result of EPSDT and subject to medical necessity and preauthorization requirements specified under Dental Services.

12c. Prosthetic devices.

A. Prosthetics services shall mean the replacement of missing arms and legs. Nothing in this regulation shall be construed to refer to orthotic services or devices.

B. Prosthetic devices (artificial arms and legs, and their necessary supportive attachments) are provided when prescribed by a physician or other licensed practitioner of the healing arts within the scope of their professional licenses as defined by state law. This service, when provided by an authorized vendor, must be medically necessary, and preauthorized for the minimum applicable component necessary for the activities of daily living.

12d. Eyeglasses.

Eyeglasses shall be reimbursed for all recipients younger than 21 years of age according to medical necessity when provided by practitioners as licensed under the Code of Virginia.

§ 13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13a. Diagnostic services.

Not provided.

13b. Screening services.

Not provided.

13c. Preventive services.

Not provided.

13d. Rehabilitative services.

A. Intensive physical rehabilitation.

1. Medicaid covers intensive inpatient rehabilitation services as defined in subdivision A 4 in facilities certified as rehabilitation hospitals or rehabilitation units in acute care hospitals which have been certified by the Department of Health to meet the requirements to be excluded from the Medicare Prospective Payment System.

2. Medicaid covers intensive outpatient physical rehabilitation services as defined in subdivision A 4 in facilities which are certified as Comprehensive Outpatient Rehabilitation Facilities (CORFs).

3. These facilities are excluded from the 21-day limit otherwise applicable to inpatient hospital services. Cost reimbursement principles are defined in Attachment 4.19-A.

4. An intensive rehabilitation program provides intensive skilled rehabilitation nursing, physical therapy, occupational therapy, and, if needed, speech therapy, cognitive rehabilitation, prosthetic-orthotic services, psychology, social work, and therapeutic recreation. The nursing staff must support the other disciplines in carrying out the activities of daily living, utilizing correctly the training received in therapy and furnishing other needed nursing services. The day-to-day activities must be carried out under the continuing direct supervision of a physician with special training or experience in the field of rehabilitation.

5. Nothing in this regulation is intended to preclude DMAS from negotiating individual contracts with in-state intensive physical rehabilitation facilities for those individuals with special intensive rehabilitation needs.

B. Community mental health services.

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

"Code" means the Code of Virginia.

"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.

"DMHMRSAS" means Department of Mental Health, Mental Retardation and Substance Abuse Services consistent with Chapter l(§ 37.1-39 et seq.) of Title 37.1 of the Code of Virginia.

1. Mental health services. The following services, with their definitions, shall be covered:

a. Intensive in-home services for children and adolescents under age 21 shall be time-limited interventions provided typically but not solely in the residence of an individual who is at risk of being moved into an out-of-home placement or who is being transitioned to home from out-of-home placement due to a disorder diagnosable under the Diagnostic and Statistical Manual of Mental Disorders-III-R (DSM-III-R). These services provide crisis treatment; individual and family counseling; life (e.g., counseling to assist parents to understand and practice proper child nutrition, child health care, personal hygiene, and financial management, etc.), parenting (e.g., counseling to assist parents to understand and practice proper nurturing and discipline, and behavior management, etc.), and communication skills (e.g., counseling to assist parents to understand and practice appropriate problem-solving, anger management, and interpersonal interaction, etc.); case management activities and coordination with other required services; and 24-hour emergency response. These services shall be limited annually to 26 weeks.

b. Therapeutic day treatment for children and adolescents shall be provided in sessions of two or more hours per day, to groups of seriously emotionally disturbed children and adolescents or children at risk of serious emotional disturbance in order to provide therapeutic interventions. Day treatment programs, limited annually to 260 days, provide evaluation, medication education and management, opportunities to learn and use daily living skills and to enhance social and interpersonal skills (e.g., problem solving, anger management, community responsibility, increased impulse control and appropriate peer relations, etc.), and individual, group and family counseling.

c. Day treatment/partial hospitalization services for adults 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 260 days, include the major diagnostic, medical, psychiatric, psychosocial and psychoeducational treatment modalities designed for individuals with serious mental disorders who require coordinated, intensive, comprehensive, and multidisciplinary treatment.

d. Psychosocial rehabilitation for adults shall be provided in sessions of two or more consecutive hours per day to groups of individuals in a nonresidential setting. These services, limited annually to 312 days, include assessment, medication education, psychoeducation, opportunities to learn and use independent living skills and to enhance social and interpersonal skills, family support, and education within a supportive and normalizing program structure and environment.

e. Crisis intervention shall provide immediate mental health care, available 24 hours a day, seven days per week, to assist individuals who are experiencing acute mental 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, limited annually to 180 hours, shall include assessing the crisis situation, providing short-term counseling designed to stabilize the individual or the family unit or both, 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, but are not limited to, office visits, home visits, preadmission screenings, telephone contacts, and other client-related activities for the prevention of institutionalization.

2. Mental retardation services. Day health and rehabilitation services shall be covered and the following definitions shall apply:

a. Day health and rehabilitation services (limited to 500 units per year) shall provide individualized activities, supports, training, supervision, and transportation based on a written plan of care to eligible persons for two or more hours per day scheduled multiple times per week. These services are intended to improve the recipient's condition or to maintain an optimal level of functioning, as well as to ameliorate the recipient's disabilities or deficits by reducing the degree of impairment or dependency. Therapeutic consultation to service providers, family, and friends of the client around implementation of the plan of care may be included as part of the services provided by the day health and rehabilitation program. The provider [~~must~~ shall] be licensed by DMHMRSAS as a Day Support Program. Specific components of day health and rehabilitation services include the following as needed:

(1) Self-care and hygiene skills;

(2) Eating and toilet training skills;

(3) Task learning skills;

(4) Community resource utilization skills (e.g., training in time, telephone, basic computations with money, warning sign recognition, and personal identifications, etc.);

(5) Environmental and behavior skills (e.g., training in punctuality, self-discipline, care of personal belongings and respect for property and in wearing proper clothing for the weather, etc.);

(6) Medication management;

(7) Travel and related training to and from the training sites and service and support activities;

(8) Skills related to the above areas, as appropriate that will enhance or retain the recipient's functioning.

b. There shall be two levels of day health and rehabilitation services: Level I and Level II.

(1) Level I services shall be provided to individuals who meet the basic program eligibility requirements.

(2) Level II services may be provided to individuals who meet the basic program eligibility requirements and for whom one or more of the following indicators are present.

(a) The individual requires physical assistance to meet basic personal care needs (toilet training, feeding, medical conditions that require special attention).

(b) The individual has extensive disability-related difficulties and requires additional, ongoing support to fully participate in programming and to accomplish individual service goals.

(c) The individual requires extensive personal care or constant supervision to reduce or eliminate behaviors which preclude full participation in programming. A formal, written behavioral program is required to address behaviors such as, but not limited to, severe depression, self injury, aggression, or self-stimulation.

§ 14. Services for individuals age 65 or older in institutions for mental diseases.

14a. Inpatient hospital services.

Provided, no limitations.

14b. Skilled nursing facility services.

Provided, no limitations.

14c. Intermediate care facility.

Provided, no limitations.

§ 15. Intermediate care services and intermediate care services for institutions for mental disease and mental retardation.

15a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with § 1902 (a)(31)(A) of the Act, to be in need of such care.

Provided, no limitations.

15b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

Provided, no limitations.

§ 16. Inpatient psychiatric facility services for individuals under 22 years of age.

Not provided.

§ 17. Nurse-midwife services.

Covered services for the nurse midwife are defined as those services allowed under the licensure requirements of the state statute and as specified in the Code of Federal Regulations, i.e., maternity cycle.

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

A. Covered hospice services shall be defined as those services allowed under the provisions of Medicare law and regulations as they relate to hospice benefits and as specified in the Code of Federal Regulations, Title 42, Part 418.

B. Categories of care.

As described for Medicare and applicable to Medicaid, hospice services shall entail the following four categories of daily care:

1. Routine home care is at-home care that is not continuous.

2. Continuous home care consists of at-home care that is predominantly nursing care and is provided as short-term crisis care. A registered or licensed practical nurse must provide care for more than half of the period of the care. Home health aide or homemaker services may be provided in addition to nursing care. A minimum of [~~8~~ *eight*] hours of care per day must be provided to qualify as continuous home care.

3. Inpatient respite care is short-term inpatient care provided in an approved facility (freestanding hospice, hospital, or nursing facility) to relieve the primary caregiver(s) providing at-home care for the recipient. Respite care is limited to not more than [~~5~~ *five*] consecutive days.

4. General inpatient care may be provided in an approved freestanding hospice, hospital, or nursing facility. This care is usually for pain control or acute or chronic symptom management which cannot be successfully treated in another setting.

C. Covered services.

1. As required under Medicare and applicable to Medicaid, the hospice itself [~~must~~ *shall*] provide all or substantially all of the "core" services applicable for the terminal illness which are nursing care, physician services, social work, and counseling (bereavement, dietary, and spiritual).

2. Other services applicable for the terminal illness that [~~must~~ *shall*] be available but are not considered "core" services are drugs and biologicals, home health aide and homemaker services, inpatient care, medical supplies, and occupational and physical therapies and speech-language pathology services.

3. These other services may be arranged, such as by contractual agreement, or provided directly by the hospice.

4. To be covered, a certification that the individual is terminally ill [~~must~~ *shall*] have been completed by the physician and hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions. The individual must elect hospice care and a plan of care must be established before services are provided. To be covered, services [~~must~~ *shall*] be consistent with the plan of care. Services not specifically documented in the patient's medical record as having been rendered will be deemed not to have been rendered and no coverage will be provided.

5. All services [~~must~~ *shall*] be performed by appropriately qualified personnel, but it is the nature of the service, rather than the qualification of the person who provides it, that determines the coverage category of the service. The following services are

covered hospice services:

a. Nursing care. Nursing care [~~must~~ *shall*] be provided by a registered nurse or by a licensed practical nurse under the supervision of a graduate of an approved school of professional nursing and who is licensed as a registered nurse.

b. Medical social services. Medical social services [~~must~~ *shall*] be provided by a social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education, and who is working under the direction of a physician.

c. Physician services. Physician services [~~must~~ *shall*] be performed by a professional who is licensed to practice, who is acting within the scope of his or her license, and who is a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor. The hospice medical director or the physician member of the interdisciplinary team [~~must~~ *shall*] be a licensed doctor of medicine or osteopathy.

d. Counseling services. Counseling services [~~must~~ *shall*] be provided to the terminally ill individual and the family members or other persons caring for the individual at home. Bereavement counseling consists of counseling services provided to the individual's family up to one year after the individual's death. Bereavement counseling is a required hospice service, but it is not reimbursable.

e. Short-term inpatient care. Short-term inpatient care may be provided in a participating hospice inpatient unit, or a participating hospital or nursing facility. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management which cannot be provided in other settings. Inpatient care may also be furnished to provide respite for the individual's family or other persons caring for the individual at home.

f. Durable medical equipment and supplies. Durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness is covered. Medical supplies include those that are part of the written plan of care.

g. Drugs and biologicals. Only drugs used which are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered.

h. Home health aide and homemaker services. Home health aides providing services to hospice recipients must meet the qualifications specified for home health aides by 42 CFR 484.36. Home health aides may provide personal care services. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient. Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment and services to enable the individual to carry out the plan of care. Home health aide and homemaker services must be provided under the general supervision of a registered nurse.

i. Rehabilitation services. Rehabilitation services include physical and occupational therapies and speech-language pathology services that are used for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

D. Eligible groups.

To be eligible for hospice coverage under Medicare or Medicaid, the recipient must have a life expectancy of six months or less, have knowledge of the illness and life expectancy, and elect to receive hospice services rather than active treatment for the illness. Both the attending physician and the hospice medical director must certify the life expectancy. The hospice must obtain the certification that an individual is terminally ill in accordance with the following procedures:

1. For the first 90-day period of hospice coverage, the hospice must obtain, within two calendar days after the period begins, a written certification statement signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and the individual's attending physician if the individual has an attending physician. For the initial 90-day period, if the hospice cannot obtain written certifications within two calendar days, it must obtain oral certifications within two calendar days, and written certifications no later than eight calendar days after the period begins.

2. For any subsequent 90-day or 30-day period or a subsequent extension period during the individual's lifetime, the hospice must obtain, no later than two calendar days after the beginning of that period, a written certification statement prepared by the medical director of the hospice or the physician member of the hospice's interdisciplinary group. The certification must include the statement that the individual's medical prognosis is that his or her life expectancy is six months or less and the signature(s) of the physician(s). The hospice must maintain the certification statements.

§ 19. Case management services for high-risk pregnant women and children up to age 1, as defined in

Supplement 2 to Attachment 3.1-A in accordance with § 1915(g)(1) of the Act.

Provided, with limitations. See Supplement 2 for detail.

§ 20. Extended services to pregnant women.

20a. Pregnancy-related and postpartum services for 60 days after the pregnancy ends.

The same limitations on all covered services apply to this group as to all other recipient groups.

20b. Services for any other medical conditions that may complicate pregnancy.

The same limitations on all covered services apply to this group as to all other recipient groups.

§ 21. Any other medical care and any other type of remedial care recognized under state law, specified by the Secretary of Health and Human Services.

21a. Transportation.

Nonemergency transportation is administered by local health department jurisdictions in accordance with reimbursement procedures established by the Program.

21b. Services of Christian Science nurses.

Not provided.

21c. Care and services provided in Christian Science sanitoria.

Provided, no limitations.

21d. Skilled nursing facility services for patients under 21 years of age.

Provided, no limitations.

21e. Emergency hospital services.

Provided, no limitations.

21f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

Not provided.

Emergency Services for Aliens (17.e)

No payment shall be made for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law unless such services are necessary for the treatment of an emergency medical condition of the alien.

Emergency services are defined as:

Emergency treatment of accidental injury or medical condition (including emergency labor and delivery) manifested by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical/surgical attention could reasonably be expected to result in:

1. Placing the patient's health in serious jeopardy;

2. Serious impairment of bodily functions; or

3. Serious dysfunction of any bodily organ or part.

Medicaid eligibility and reimbursement is conditional upon review of necessary documentation supporting the need for emergency services. Services and inpatient lengths of stay cannot exceed the limits established for other Medicaid recipients.

Claims for conditions which do not meet emergency critieria for treatment in an emergency room or for acute care hospital admissions for intensity of service or severity of illness will be denied reimbursement by the Department of Medical Assistance Services.

VR 460-03-3.1102. Case Management Services.

§ 1. High risk pregnant women and children.

A. Target group.

To reimburse case management services for high-risk Medicaid eligible pregnant women and children up to age two.

B. Areas of state in which services will be provided:

☒ Entire state.

☐ Only in the following geographic areas (authority of § 1915(g)(1) of the Act is invoked to provide services less than statewide.

C. Comparability of services.

☐ Services are provided in accordance with § 1902(a)(10)(B) of the Act.

☒ Services are not comparable in amount, duration, and scope. Authority of § 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of § 1902(a)(10)(B) of the Act.

D. Definition of services.

The case management services will provide maternal and child health coordination to minimize fragmentation of

care, reduce barriers, and link clients with appropriate services to ensure comprehensive, continuous health care. The Maternity Care Coordinator will provide:

1. Assessment. Determining clients' service needs, which include psychosocial, nutrition, medical, and educational factors.

2. Service planning. Developing an individualized description of what services and resources are needed to meet the service needs of the client and help access those resources.

3. Coordination and referral. Assisting the client in arranging for appropriate services and ensuring continuity of care.

4. Follow-up and monitoring. Assessing ongoing progress and ensuring services are delivered.

5. Education and counseling. Guiding the client and developing a supportive relationship that promotes the service plan.

E. Qualifications of providers.

Any duly enrolled provider which the department determines is qualified who has signed an agreement with Department of Medical Assistance Services to deliver Maternity Care Coordination services. Qualified service providers will provide case management regardless of their capacity to provide any other services under the Plan. A Maternity Care Coordinator is the Registered Nurse or Social Worker employed by a qualified service provider who provides care coordination services to eligible clients. The RN must be licensed in Virginia and should have a minimum of one year of experience in community health nursing and experience in working with pregnant women. The Social Worker (MSW, BSW) must have a minimum of one year of experience in health and human services, and have experience in working with pregnant women and their families. The Maternity Care Coordinator assists clients in accessing the health care and social service system in order that outcomes which contribute to physical and emotional health and wellness can be obtained.

F. The state assures that the provision of case management services will not restrict an individual's free choice of providers in violation of § 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

§ 2. Seriously mentally ill adults and emotionally disturbed children.

A. Target Group.

The Medicaid eligible individual shall meet the DMHMRSAS definition for "serious mental illness," or "serious emotional disturbance in children and adolescents."

1. An active client for case management shall mean an individual for whom there is a plan of care in effect which requires regular direct or client-related contacts or communication or activity with the client, family, [significant others,] service providers, [~~significant others~~] and others including a minimum of one face-to-face 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. There shall be no maximum service limits for case management services except case management services for individuals residing in institutions or medical facilities. For these individuals, reimbursement for case management shall be limited to 30 days immediately preceding discharge. Case management for institutionalized individuals may be billed for no more than two predischarge periods in 12 months.

B. Areas of state in which services will be provided:

☒ *Entire state.*

☐ *Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:*

C. Comparability of services.

☐ *Services are provided in accordance with section 1902(a)(10)(B) of the Act.*

☒ *Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.*

D. Definition of services; mental health services.

Case management services assist individual children and adults, in accessing needed medical, psychiatric, social, educational, vocational, and other supports essential to meeting basic needs. Services to be provided include:

1. Assessment and planning services, to include developing an Individual Service Plan (does not include performing medical and psychiatric assessment but does include referral for such assessment);

2. Linking the individual to services and supports

specified in the individualized service plan;

3. Assisting the individual directly for the purpose of locating, developing or obtaining needed services and resources;

4. Coordinating services and service planning with other agencies and providers involved with the individual;

5. Enhancing community integration by contacting other entities to arrange community access and involvement, including opportunities to learn community living skills and use vocational, civic, and recreational services;

6. Making collateral contacts with the individuals' significant others to promote implementation of the service plan and community adjustment;

7. Follow-up and monitoring to assess ongoing progress and to ensure services are delivered; and

8. Education and counseling which guides the client and develops a supportive relationship that promotes the service plan.

E. Qualifications of providers.

1. Services are not comparable in amount, duration, and scope. Authority of § 1915(g)(1) of the Act is invoked to limit case management providers for individuals with mental retardation and individuals with serious/chronic mental illness to the Community Services Boards only to enable them to provide services to seriously/chronically mentally ill or mentally retarded individuals without regard to the requirements of § 1902(a)(10)(B) of the Act.

2. To qualify as a provider of services through DMAS for rehabilitative mental health case management, the provider of the services must meet certain criteria. These criteria shall be:

a. The provider [~~must~~ shall] guarantee that clients have access to emergency services on a 24-hour basis;

b. The provider [~~must~~ shall] demonstrate the ability to serve individuals in need of comprehensive services regardless of the individual's ability to pay or eligibility for Medicaid reimbursement;

c. The provider [~~must~~ shall] have the administrative and financial management capacity to meet state and federal requirements;

d. The provider [~~must~~ shall] have the ability to document and maintain individual case records in accordance with state and federal requirements;

e. The services shall be in accordance with the Virginia Comprehensive State Plan for Mental Health, Mental Retardation and Substance Abuse Services; and

f. The provider [~~must~~ shall] be certified as a mental health case management agency by the DMHMRSAS.

3. Providers may bill Medicaid for mental health case management only when the services are provided by qualified mental health case managers. The case manager [~~must~~ shall] possess a combination of mental health work experience or relevant education which indicates that the individual possesses the following knowledge, skills, and abilities. The incumbent [~~must~~ shall] have at entry level the following knowledge, skills and abilities. These [~~must~~ shall] be documented or observable in the application form or supporting documentation or in the interview (with appropriate documentation).

a. Knowledge of:

(1) The nature of serious mental illness in adults and serious emotional disturbance in children and adolescents;

(2) Treatment modalities and intervention techniques, such as behavior management, independent living skills training, supportive counseling, family education, crisis intervention, discharge planning and service coordination;

(3) Different types of assessments, including functional assessment, and their uses in service planning;

(4) Consumers' rights;

(5) Local community resources and service delivery systems, including support services (e.g. housing, financial, social welfare, dental, educational, transportation, communication, recreational, vocational, legal/advocacy), eligibility criteria and intake processes, termination criteria and procedures, and generic community resources (e.g. churches, clubs, self-help groups);

(6) Types of mental health programs and services;

(7) Effective oral, written and interpersonal communication; principles and techniques;

(8) General principles of record documentation; and

(9) The service planning process and major components of a service plan.

b. Skills in:

(1) Interviewing;

(2) Observing, recording and reporting on an individual's functioning;

(3) Identifying and documenting a consumer's needs for resources, services and other supports;

(4) Using information from assessments, evaluations, observation and interviews to develop service plans;

(5) Identifying services within the community and established service system to meet the individual's needs;

(6) Formulating, writing and implementing individualized service plans to promote goal attainment for [~~*seriously mentally ill and emotionally disturbed*~~] *persons* [*with serious mental illness and emotional disturbances*] *;*

(7) Negotiating with consumers and service providers;

(8) Coordinating the provision of services by diverse public; and private providers;

(9) Identifying community resources and organizations and coordinating resources and activities; and

(10) Using assessment tools (e.g. level of function scale, life profile scale).

c. Abilities to:

(1) Demonstrate a positive regard for consumers and their families (e.g. treating consumers as individuals, allowing risk taking, avoiding stereotypes of [~~*mentally ill*~~] *people* [*with mental illness*] *, respecting consumers' and families' privacy, believing consumers are valuable members of society);*

(2) Be persistent and remain objective;

(3) Work as a team member, maintaining effective inter- and intra-agency working relationships;

(4) Work independently, performing position duties under general supervision;

(5) Communicate effectively, verbally and in writing; and

(6) Establish and maintain ongoing supportive relationships.

F. The state assures that the provision of case management services will not restrict an individual's free choice of providers in violation of § 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

§ 3. Youth at risk of serious emotional disturbance.

A. Target Group.

Medicaid eligible individuals who meet the DMHMRSAS definition of youth at risk of serious emotional disturbance.

1. An active client shall mean an individual for whom there is a plan of care in effect which requires regular direct or client-related contacts or communication or activity with the client, family, service providers, significant others and others including a minimum of one face-to-face 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. There shall be no maximum service limits for case management services except case management services for individuals residing in institutions or medical facilities. For these individuals, reimbursement for case management shall be limited to thirty days immediately preceding discharge. Case management for institutionalized individuals may be billed for no more than two predischarge periods in 12 months.

B. Areas of state in which services will be provided:

☒ *Entire state.*

☐ *Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:*

C. Comparability of services.

☐ *Services are provided in accordance with section 1902(a)(10)(B) of the Act.*

☒ *Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.*

D. Definition of services; mental health services.

Case management services assist youth at risk of serious emotional disturbance in accessing needed medical, psychiatric, social, educational, vocational, and other

supports essential to meeting basic needs. Services to be provided include:

1. Assessment and planning services, to include developing an Individual Service Plan;

2. Linking the individual directly to services and supports specified in the treatment/services plan;

3. Assisting the individual directly for the purpose of locating, developing or obtaining needed services and resources;

4. Coordinating services and service planning with other agencies and providers involved with the individual;

5. Enhancing community integration by contacting other entities to arrange community access and involvement, including opportunities to learn community living skills, and use vocational, civic, and recreational services;

6. Making collateral contacts which are nontherapy contacts with an individual's significant others to promote treatment or community adjustment;

7. Following-up and monitoring to assess ongoing progress and ensuring services are delivered; and

8. Education and counseling which guides the client and develops a supportive relationship that promotes the service plan.

E. Qualifications of providers.

1. To qualify as a provider of case management services to youth at risk of serious emotional disturbance, the provider of the services must meet certain criteria. These criteria shall be:

a. The provider [~~must~~ shall] guarantee that clients have access to emergency services on a 24-hour basis;

b. The provider [~~must~~ shall] demonstrate the ability to serve individuals in need of comprehensive services regardless of the individual's ability to pay or eligibility for Medicaid reimbursement;

c. The provider [~~must~~ shall] have the administrative and financial management capacity to meet state and federal requirements;

d. The provider [~~must~~ shall] have the ability to document and maintain individual case records in accordance with state and federal requirements;

e. The services shall be in accordance with the Virginia Comprehensive State Plan for Mental Health, Mental Retardation and Substance Abuse Services; and

f. The provider [~~must~~ shall] be certified as a mental health case management agency by the DMHMRSAS.

2. Providers may bill Medicaid for mental health case management to youth at risk of serious emotional disturbance only when the services are provided by qualified mental health case managers. The case manager [~~must~~ shall] possess a combination of mental health work experience or relevant education which indicates that the individual possesses the following knowledge, skills, and abilities. The incumbent [~~must~~ shall] have at entry level the following knowledge, skills and abilities. These [~~must~~ shall] be documented or observable in the application form or supporting documentation or in the interview (with appropriate documentation).

a. Knowledge of:

(1) The nature of serious mental illness in adults and serious emotional disturbance in children and adolescents;

(2) Treatment modalities and intervention techniques, such as behavior management, independent living skills training, supportive counseling, family education, crisis intervention, discharge planning and service coordination;

(3) Different types of assessments, including functional assessment, and their uses in service planning;

(4) Consumer's rights;

(5) Local community resources and service delivery systems, including support services (e.g. housing, financial, social welfare, dental, educational, transportation, communication, recreational, vocational, legal/advocacy), eligibility criteria and intake processes, termination criteria and procedures, and generic community resources (e.g. churches, clubs, self-help groups);

(6) Types of mental health programs and services;

(7) Effective oral, written and interpersonal communication principles and techniques;

(8) General principles of record documentation; and

(9) The service planning process and major components of a service plan.

b. Skills in:

(1) Interviewing;

(2) Observing, recording and reporting on an individual's functioning;

(3) Identifying and documenting a consumer's needs for resources, services and other supports;

(4) Using information from assessments, evaluations, observation and interviews to develop service plans;

(5) Identifying services within the community and established service system to meet the individual's needs;

(6) Formulating, writing and implementing individualized service plans to promote goal attainment for [~~*seriously mentally ill and emotionally disturbed*~~] *persons* [*with serious mental illness and emotional disturbances*] *;*

(7) Negotiating with consumers and service providers;

(8) Coordinating the provision of services by diverse public and private providers;

(9) Identifying community resources and organizations and coordinating resources and activities; and

(10) Using assessment tools (e.g. level of function scale, life profile scale).

c. Abilities to:

(1) Demonstrate a positive regard for consumers and their families (e.g. treating consumers as individuals, allowing risk taking, avoiding stereotypes of [~~*mentally ill*~~] *people* [*with mental illness*] *, respecting consumers' and families' privacy, believing consumers are valuable members of society);*

(2) Be persistent and remain objective;

(3) Work as a team member, maintaining effective inter- and intra- agency working relationships;

(4) Work independently, performing position duties under general supervision;

(5) Communicate effectively, verbally and in writing; and

(6) Establish and maintain ongoing supportive relationships.

F. The state assures that the provision of case management services will not restrict an individual's free choice of providers in violation of § 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

§ 4. Individuals with mental retardation.

A. Target group.

Medicaid eligible individuals who are mentally retarded as defined in state law.

1. An active client for mental retardation case management shall mean an individual for whom there is a plan of care in effect which requires regular direct or client-related contacts or communication or activity with the client, family, service providers, significant others and others including a minimum of one face-to-face 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. There shall be no maximum service limits for case management services except case management services for individuals residing in institutions or medical facilities. For these individuals, reimbursement for case management shall be limited to thirty days immediately preceding discharge. Case management for institutionalized individuals be billed for no more than two predischarge periods in twelve months.

B. Areas of state in which services will be provided:

☒ *Entire state.*

☐ *Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than statewide:*

C. Comparability of services.

☐ *Services are provided in accordance with section 1902(a)(10)(B) of the Act.*

☒ *Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.*

D. Definition of services.

Mental retardation services to be provided include:

1. Assessment and planning services, to include developing a Consumer Service Plan (does not include

performing medical and psychiatric assessment but does include referral for such assessment);

2. Linking the individual to services and supports specified in the consumer service plan;

3. Assisting the individual directly for the purpose of locating, developing or obtaining needed services and resources;

4. Coordinating services and service planning with other agencies and providers involved with the individual;

5. Enhancing community integration by contacting other entities to arrange community access and involvement, including opportunities to learn community living skills, and use vocational, civic and recreational services;

6. Making collateral contacts with the individual's significant others to promote implementation of the service plan and community adjustment;

7. Following-up and monitoring to assess ongoing progress and ensuring services are delivered; and

8. Education and counseling which guides the client and develops a supportive relationship that promotes the service plan.

E. Qualifications of providers.

1. Services are not comparable in amount, duration, and scope. Authority of § 1915(g)(1) of the Act is invoked to limit case management providers for individuals with mental retardation and serious/chronic mental illness to the Community Services Boards only to enable them to provide services to serious/chronically mentally ill or mentally retarded individuals without regard to the requirements of § 1902(a)(10)(B) of the Act.

2. To qualify as a provider of services through DMAS for rehabilitative mental retardation case management, the provider of the services must meet certain criteria. These criteria shall be:

a. The provider [~~must~~ shall] guarantee that clients have access to emergency services on a 24-hour basis;

b. The provider [~~must~~ shall] demonstrate the ability to serve individuals in need of comprehensive services regardless of the individual's ability to pay or eligibility for Medicaid reimbursement;

c. The provider [~~must~~ shall] have the administrative and financial management capacity to meet state and federal requirements;

d. The provider [~~must~~ shall] have the ability to document and maintain individual case records in accordance with state and federal requirements;

e. The services shall be in accordance with the Virginia Comprehensive State Plan for Mental Health, Mental Retardation and Substance Abuse Services; and

f. The provider [~~must~~ shall] be certified as a mental retardation case management agency by the DMHMRSAS.

3. Providers may bill for Medicaid mental retardation case management only when the services are provided by qualified mental retardation case managers. The case manager [~~must~~ shall] possess a combination of mental retardation work experience or relevant education which indicates that the individual possesses the following knowledge, skills, and abilities. The incumbent [~~must~~ shall] have at entry level the following knowledge, skills and abilities. These [~~must~~ shall] be documented or observable in the application form or supporting documentation or in the interview (with appropriate documentation).

a. Knowledge of:

(1) The definition, causes and program philosophy of mental retardation;

(2) Treatment modalities and intervention techniques, such as behavior management, independent living skills training, supportive counseling, family education, crisis intervention, discharge planning and service coordination;

(3) Different types of assessments and their uses in program planning;

(4) Consumers' rights;

(5) Local [community resources and] service delivery systems, including support services [, eligibility critria and intake process, termination criteria and procedures and generic community resources] ;

(6) Types of mental retardation programs and services;

(7) Effective oral, written and interpersonal communication principles and techniques;

(8) General principles of record documentation; and

(9) The service planning process and the major components of a service plan.

b. Skills in:

(1) Interviewing;

(2) Negotiating with consumers and service providers;

(3) Observing, recording and reporting behaviors;

(4) Identifying and documenting a consumer's needs for resources, services and other assistance;

(5) Identifying services within the established service system to meet the consumer's needs;

(6) Coordinating the provision of services by diverse public and private providers;

(7) [~~*Analyzing and planning for the service needs of mentally retarded persons*~~ *Using information from assessments, evaluations, observation and interviews to develop service plans*] ;

(8) Formulating, writing and implementing individualized consumer service plans to promote goal attainment for individuals with mental retardation; and

(9) Using assessment tools.

c. Abilities to:

(1) Demonstrate a positive regard for consumers and their families (e.g. treating consumers as individuals, allowing risk taking, avoiding stereotypes of [~~*mentally retarded*~~] *people* [*with mental retardation*] *, respecting consumers' and families' privacy, believing consumers can grow);*

(2) Be persistent and remain objective;

(3) Work as team member, maintaining effective inter- and intra-agency working relationships;

(4) Work independently, performing position duties under general supervision;

(5) Communicate effectively, verbally and in writing; and

(6) Establish and maintain ongoing supportive relationships.

F. The state assures that the provision of case management services will not restrict an individual's free choice of providers in violation of § 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

§ 5. Individuals with mental retardation and related conditions who are participants in the home and community-based care waivers for persons with mental retardation and related conditions.

A. Target group.

Medicaid eligible individuals with mental retardation and related conditions, or a child under six years of age who is at developmental risk, who have been determined to be eligible for home and community based care waiver services for persons with mental retardation and related conditions. An active client for waiver case management shall mean an individual who receives a minimum of one face-to-face contact every two months and monthly on-going case management interactions. There shall be no maximum service limits for case management services. Case management services must be preauthorized by DMAS after review and recommendation by the care coordinator employed by DMHMRSAS and verification of waiver eligibility.

B. Areas of state in which services will be provided:

☒ Entire State

☐ Only in the following geographic areas (authority of § 1915(g)(1) of the Act is invoked to provide services less than statewide.

C. Comparability of services.

☐ Services are provided in accordance with § 1902(a)(10)(B) of the Act.

☒ Services are not comparable in amount, duration, and scope. Authority of § 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of § 1902(a)(10)(B) of the Act.

D. Definition of services.

Mental retardation case management services to be provided include:

1. Assessment and planning services to include developing a Consumer Service Plan (does not include performing medical and psychiatric assessment but does include referral for such assessment);

2. Linking the individual to services and supports specified in the consumer service plan;

3. Assisting the individual directly for the purpose of locating, developing or obtaining needed services and resources;

4. Coordinating services with other agencies and providers involved with the individual;

5. Enhancing community integration by contacting other entities to arrange community access and involvement, including opportunities to learn community living skills, and use vocational, civic and recreational services;

6. Making collateral contacts with the individual's significant others to promote implementation of the service plan and community adjustment;

7. Following-up and monitoring to assess ongoing progress and ensuring services are delivered: and

8. Education and counseling which guide the client and develop a supportive relationship that promotes the service plan.

E. Qualifications of providers.

1. Services are not comparable in amount, duration, and scope. Authority of § 1915(g)(1) of the Act is invoked to limit case management providers for individuals with mental retardation and serious/chronic mental illness to the community services boards only to enable them to provide services to seriously/chronically mentally ill or mentally retarded individuals without regard to the requirements of § 1902(a)(10)(B) of the Act.

2. To qualify as a provider of services through DMAS for rehabilitative mental retardation case management, the provider of the services must meet certain criteria. These criteria shall be:

a. The provider [~~must~~ *shall*] guarantee that clients have access to emergency services on a 24-hour basis;

b. The provider [~~must~~ *shall*] demonstrate the ability to serve individuals in need of comprehensive services regardless of the individuals' ability to pay or eligibility for Medicaid reimbursement;

c. The provider [~~must~~ *shall*] have the administrative and financial management capacity to meet state and federal requirements;

d. The provider [~~must~~ *shall*] have the ability to document and maintain individual case records in accordance with state and federal requirements;

e. The services shall be in accordance with the Virginia Comprehensive State Plan for Mental Health, Mental Retardation and Substance Abuse Services; and

f. The provider [~~must~~ *shall*] be certified as a mental retardation case management agency by the DMHMRSAS.

3. Providers may bill for Medicaid mental retardation case management only when the services are provided by qualified mental retardation case managers. The case manager [~~must~~ *shall*] possess a combination of mental retardation work experience or relevant education which indicates that the individual possesses the following knowledge, skills, and abilities at the entry level. These [~~must~~ *shall*] be documented or observable in the application form or supporting documentation or in the interview (with appropriate documentation).

a. Knowledge of:

(1) The definition, causes and program philosophy of mental retardation,

(2) Treatment modalities and intervention techniques, such as behavior management, independent living skills training, supportive counseling, family education, crisis intervention, discharge planning and service coordination,

(3) Different types of assessments and their uses in program planning,

(4) Consumers' rights,

(5) Local service delivery systems, including support services,

(6) Types of mental retardation programs and services.

(7) Effective oral, written and interpersonal communication principles and techniques,

(8) General principles of record documentation, and

(9) The service planning process and the major components of a service plan.

b. Skills in:

(1) Interviewing,

(2) Negotiating with consumers and service providers,

(3) Observing, recording and reporting behaviors,

(4) Identifying and documenting a consumer's needs for resources, services and other assistance,

(5) Identifying services within the established service system to meet the consumer's needs,

(6) Coordinating the provision of services by diverse public and private providers,

(7) Analyzing and planning for the service needs of mentally retarded persons,

(8) Formulating, writing and implementing individualized consumer service plans to promote goal attainment for individuals with mental retardation, and

(9) Using assessment tools.

c. Abilities to:

(1) Demonstrate a positive regard for consumers and their families (e.g., treating consumers as individuals, allowing risk taking, avoiding stereotypes of mentally retarded people, respecting consumers' and families' privacy, believing consumers can grow),

(2) Be persistent and remain objective,

(3) Work as team member, maintaining effective interagency and intraagency working relationships,

(4) Work independently, performing position duties under general supervision,

(5) Communicate effectively, verbally and in writing, and

(6) Establish and maintain ongoing supportive relationships.

F. The state assures that the provision of case management services will not restrict an individual's free choice of providers in violation of § 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

VR 460-02-3.1300. Standards Established and Methods Used to Assure High Quality of Care.

The following is a description of the standards and the methods that will be used to assure that the medical and remedial care and services are of high quality:

§ 1. Institutional care will be provided by facilities qualified to participate in Title XVIII and/or Title XIX.

§ 2. Utilization control.

A. Hospitals.

1. The Commonwealth of Virginia is required by state law to take affirmative action on all hospital stays that approach 15 days. It is a requirement that the hospitals submit to the Department of Medical Assistance Services complete information on all hospital stays where there is a need to exceed 15 days. The various documents which are submitted are reviewed by professional program staff, including a physician who determines if additional hospitalization is indicated. This review not only serves as a mechanism for approving additional days, but allows physicians on the Department of Medical Assistance Services' staff to evaluate patient documents and give the Program an insight into the quality of care by individual patient. In addition, hospital representatives of the Medical Assistance Program visit hospitals, review the minutes of the Utilization Review Committee, discuss patient care, and discharge planning.

2. In each case for which payment for inpatient hospital services, or inpatient mental hospital services is made under the State Plan:

a. A physician must certify at the time of admission, or if later, the time the individual applies for medical assistance under the State Plan that the individual requires inpatient hospital or mental hospital care.

b. The physician, or physician assistant under the supervision of a physician, must recertify, at least every 60 days, that patients continue to require inpatient hospital or mental hospital care.

c. Such services were furnished under a plan established and periodically reviewed and evaluated by a physician for inpatient hospital or mental hospital services.

B. Long-stay acute care hospitals (nonmental hospitals).

1. Services for adults in long-stay acute care hospitals. The population to be served includes individuals requiring mechanical ventilation, ongoing intravenous medication or nutrition administration, comprehensive rehabilitative therapy services and individuals with communicable diseases requiring universal or respiratory precautions.

a. Long-stay acute care hospital stays shall be preauthorized by the submission of a completed comprehensive assessment instrument, a physician certification of the need for long-stay acute care hospital placement, and any additional information that justifies the need for intensive services. Physician certification must accompany the request. Periods of care not authorized by DMAS shall not be approved for payment.

b. These individuals must have long-term health conditions requiring close medical supervision, the need for 24-hour licensed nursing care, and the need for specialized services or equipment needs.

c. At a minimum, these individuals must require physician visits at least once weekly, licensed nursing services 24 hours a day (a registered nurse whose sole responsibility is the designated unit must be on the nursing unit 24 hours a day on which the resident resides), and coordinated multidisciplinary team approach to meet needs that must include daily therapeutic leisure activities.

d. In addition, the individual must meet at least one of the following requirements:

(1) Must require two out of three of the following rehabilitative services: physical therapy, occupational therapy, speech-pathology services; each required therapy must be provided daily, five days per week, for a minimum of one hour each day; individual must demonstrate progress in overall rehabilitative plan of care on a monthly basis; or

(2) Must require special equipment such as mechanical ventilators, respiratory therapy equipment (that has to be supervised by a licensed nurse or respiratory therapist), monitoring device (respiratory or cardiac), kinetic therapy; or

(3) The individual must require at least one of the following special services:

(a) Ongoing administration of intravenous medications or nutrition (i.e. total parenteral nutrition (TPN), antibiotic therapy, narcotic administration, etc.);

(b) Special infection control precautions such as universal or respiratory precaution (this does not include handwashing precautions only);

(c) Dialysis treatment that is provided on-unit (i.e. peritoneal dialysis);

(d) Daily respiratory therapy treatments that must be provided by a licensed nurse or a respiratory therapist;

(e) Extensive wound care requiring debridement, irrigation, packing, etc., more than two times a day (i.e. grade IV decubiti; large surgical wounds that cannot be closed; second- or third-degree burns covering more than 10% of the body); or

(f) Ongoing management of multiple unstable ostomies (a single ostomy does not constitute a requirement for special care) requiring frequent care (i.e. suctioning every hour; stabilization of feeding; stabilization of elimination, etc.).

e. Utilization review shall be performed to determine if services are appropriately provided and to ensure that the services provided to Medicaid recipients are medically necessary and appropriate. Services not specifically documented in the individuals' medical records as having been rendered shall be deemed not to have been rendered and no coverage shall be provided.

f. When the individual no longer meets long-stay acute care hospital criteria or requires services that the facility is unable to provide, then the individual must be discharged.

2. Services to pediatric/adolescent patients in long-stay acute care hospitals. The population to be served shall include children requiring mechanical ventilation, ongoing intravenous medication or nutrition administration, daily dependence on device-based respiratory or nutritional support (tracheostomy, gastrostomy, etc.), comprehensive rehabilitative therapy services, and those children having communicable diseases requiring universal or respiratory precautions (excluding normal childhood diseases such as chicken pox, measles, strep throat, etc.) and with terminal illnesses.

a. Long-stay acute care hospital stays shall be preauthorized by the submission of a completed comprehensive assessment instrument, a physician certification of the need for long-stay acute care, and any additional information that justifies the need for intensive services. Periods of care not authorized by DMAS shall not be approved for payment.

b. The child must have ongoing health conditions requiring close medical supervision, the need for 24-hour licensed nursing supervision, and the need for specialized services or equipment. The recipient must be age 21 or under.

c. The child must minimally require physician visits at least once weekly, licensed nursing services 24 hours a day (a registered nurse whose sole responsibility is that nursing unit must be on the unit 24 hours a day on which the child is residing), and a coordinated multidisciplinary team approach to meet needs.

d. In addition, the child must meet one of the following requirements:

(1) Must require two out of three of the following physical rehabilitative services: physical therapy, occupational therapy, speech-pathology services; each required therapy must be provided daily, fivedays per week, for a minimum of 45 minutes per day; child must demonstrate progress in overall rehabilitative plan of care on a monthly basis; or

(2) Must require special equipment such as mechanical ventilators, respiratory therapy equipment (that has to be supervised by licensed nurse or respiratory therapist), monitoring device (respiratory or cardiac), kinetic therapy, etc; or

(3) Must require at least one of the following special services:

(a) Ongoing administration of intravenous medications or nutrition (i.e. total parenteral nutrition (TPN), antibiotic therapy, narcotic administration, etc.);

(b) Special infection control precautions such as universal or respiratory precaution (this does not include handwashing precautions only or isolation for normal childhood diseases such as measles, chicken pox, strep throat, etc.);

(c) Dialysis treatment that is provided within the facility (i.e. peritoneal dialysis);

(d) Daily respiratory therapy treatments that must be provided by a licensed nurse or a respiratory therapist;

(e) Extensive wound care requiring debridement, irrigation, packing, etc. more than two times a day (i.e. grade IV decubiti; large surgical wounds that cannot be closed; second- or third-degree burns covering more than 10% of the body);

(f) Ostomy care requiring services by a licensed nurse;

(g) Services required for terminal care.

e. In addition, the long-stay acute care hospital must provide for the educational and habilitative needs of the child. These services must be age appropriate, must meet state educational requirements, and must be appropriate to the child's cognitive level. Services must also be individualized to meet the child's specific needs and must be provided in an organized manner that encourages the child's participation. Services may include, but are not limited to, school, active treatment for mental retardation, habilitative therapies, social skills, and leisure activities. Therapeutic leisure activities must be provided daily.

f. Utilization review shall be performed to determine if services are appropriately provided and to ensure that the services provided to Medicaid recipients are medically necessary and appropriate. Services not specifically documented in the patient's medical record as having been rendered shall be deemed not to have been rendered and no coverage shall be provided.

g. When the resident no longer meets long-stay hospital criteria or requires services that the facility is unable to provide, the resident must be discharged.

C. Nursing facilities.

1. Long-term care of residents in nursing facilities will be provided in accordance with federal law using practices and procedures that are based on the resident's medical and social needs and requirements.

2. Nursing facilities must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. This assessment must be conducted no later than 14 days after the date of admission and promptly after a significant change in the resident's physical or mental condition. Each resident must be reviewed at least quarterly, and a complete assessment conducted at least annually.

3. The Department of Medical Assistance Services shall conduct at least annually a validation survey of the assessments completed by nursing facilities to determine that services provided to the residents are medically necessary and that needed services are provided. The survey will be composed of a sample of Medicaid residents and will include review of both current and closed medical records.

4. Nursing facilities must submit to the Department of Medical Assistance Services resident assessment information at least every six months for utilization review. If an assessment completed by the nursing facility does not reflect accurately a resident's capability to perform activities of daily living and significant impairments in functional capacity, then reimbursement to nursing facilities may be adjusted during the next quarter's reimbursement review. Any individual who willfully and knowingly certifies (or causes another individual to certify) a material and false statement in a resident assessment is subject to civil money penalties.

5. In order for reimbursement to be made to the nursing facility for a recipient's care, the recipient must meet nursing facility criteria as described in Supplement 1 to Attachment 3.1-C, Part 1 (Nursing Facility Criteria).

In order for reimbursement to be made to the nursing facility for a recipient requiring specialized care, the recipient must meet specialized care criteria as described in Supplement 1 to Attachment 3.1-C, Part 2 (Adult Specialized Care Criteria) or Part 3 (Pediatric/Adolescent Specialized Care Criteria). Reimbursement for specialized care must be preauthorized by the Department of Medical Assistance Services. In addition, reimbursement to nursing facilities for residents requiring specialized care will only be made on a contractual basis.

In each case for which payment for nursing facility services is made under the State Plan, a physician must recommend at the time of admission or, if later, the time at which the individual applies for medical assistance under the State Plan that the individual requires nursing facility care.

6. For nursing facilities, a physician must approve a recommendation that an individual be admitted to a facility. The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 90 days thereafter. At the option of the physician, required visits after the initial visit may alternate between personal visits by the physician and visits by a physician assistant or nurse practitioner.

7. When the resident no longer meets nursing facility criteria or requires services that the nursing facility is unable to provide, then the resident must be discharged.

D. Facilities for the Mentally Retarded (FMR) and Institutions for Mental Disease (IMD).

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

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

3. In order for reimbursement to be made to a facility for the mentally retarded, the resident must meet criteria for placement in such facility as described in Supplement 1, Part 4, to Attachment 3.1-C and the facility must provide active treatment for mental retardation.

4. In each case for which payment for nursing facility services for the mentally retarded or institution for mental disease services is made under the State Plan:

a. A physician must certify for each applicant or recipient that inpatient care is needed in a facility for the mentally retarded or an institution for mental disease. The certification must be made at the time of admission or, if an individual applies for assistance while in the facility, before the Medicaid agency authorizes payment; and

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

5. When a resident no longer meets criteria for facilities for the mentally retarded or an institution for mental disease or no longer requires active treatment in a facility for the mentally retarded, then the resident must be discharged.

E. Home health services.

1. Home health services which meet the standards prescribed for participation under Title XVIII will be supplied.

2. Home health services shall be provided by a licensed home health agency on a part-time or intermittent basis to a homebound recipient in his place of residence. The place of residence shall not include a hospital or nursing facility. Home health services must be prescribed by a physician and be part of a written plan of care utilizing the Home Health Certification and Plan of Treatment forms which the physician shall review at least every 62 days.

3. Except in limited circumstances described in subdivision 4 below, to be eligible for home health services, the patient must be essentially homebound. The patient does not have to be bedridden. Essentially homebound shall mean:

a. The patient is unable to leave home without the assistance of others or the use of special equipment;

b. The patient has a mental or emotional problem which is manifested in part by refusal to leave the

home environment or is of such a nature that it would not be considered safe for him to leave home unattended;

c. The patient is ordered by the physician to restrict activity due to a weakened condition following surgery or heart disease of such severity that stress and physical activity must be avoided;

d. The patient has an active communicable disease and the physician quarantines the patient.

4. Under the following conditions, Medicaid will reimburse for home health services when a patient is not essentially homebound. When home health services are provided because of one of the following reasons, an explanation must be included on the Home Health Certification and Plan of Treatment forms:

a. When the combined cost of transportation and medical treatment exceeds the cost of a home health services visit;

b. When the patient cannot be depended upon to go to a physician or clinic for required treatment, and, as a result, the patient would in all probability have to be admitted to a hospital or nursing facility because of complications arising from the lack of treatment;

c. When the visits are for a type of instruction to the patient which can better be accomplished in the home setting;

d. When the duration of the treatment is such that rendering it outside the home is not practical.

5. Covered services. Any one of the following services may be offered as the sole home health service and shall not be contingent upon the provision of another service.

a. Nursing services,

b. Home health aide services,

c. Physical therapy services,

d. Occupational therapy services,

e. Speech-language pathology services, or

f. Medical supplies, equipment, and appliances suitable for use in the home.

6. General conditions. The following general conditions apply to reimbursable home health services.

a. The patient must be under the care of a physician who is legally authorized to practice and who is acting within the scope of his or her license. The physician may be the patient's private physician or a physician on the staff of the home health agency or a physician working under an arrangement with the institution which is the patient's residence or, if the agency is hospital-based, a physician on the hospital or agency staff.

b. Services shall be furnished under a written plan of care and must be established and periodically reviewed by a physician. The requested services or items must be necessary to carry out the plan of care and must be related to the patient's condition. The written plan of care shall appear on the Home Health Certification and Plan of Treatment forms.

c. A physician recertification shall be required at intervals of at least once every 62 days, must be signed and dated by the physician who reviews the plan of care, and should be obtained when the plan of care is reviewed. The physician recertification statement must indicate the continuing need for services and should estimate how long home health services will be needed. Recertifications must appear on the Home Health Certification and Plan of Treatment forms.

d. The physician orders for therapy services shall include the specific procedures and modalities to be used, identify the specific discipline to carry out the plan of care, and indicate the frequency and duration for services.

e. The physician orders for durable medical equipment and supplies shall include the specific item identification including all modifications, the number of supplies needed monthly, and an estimate of how long the recipient will require the use of the equipment or supplies. All durable medical equipment or supplies requested must be directly related to the physician's plan of care and to the patient's condition.

f. A written physician's statement located in the medical record must certify that:

(1) The home health services are required because the individual is confined to his or her home (except when receiving outpatient services);

(2) The patient needs licensed nursing care, home health aide services, physical or occupational therapy, speech-language pathology services, or durable medical equipment and/or supplies;

(3) A plan for furnishing such services to the individual has been established and is periodically reviewed by a physician; and

(4) These services were furnished while the individual was under the care of a physician.

g. The plan of care shall contain at least the following information:

(1) Diagnosis and prognosis,

(2) Functional limitations,

(3) Orders for nursing or other therapeutic services,

(4) Orders for medical supplies and equipment, when applicable

(5) Orders for home health aide services, when applicable,

(6) Orders for medications and treatments, when applicable,

(7) Orders for special dietary or nutritional needs, when applicable, and

(8) Orders for medical tests, when applicable, including laboratory tests and x-rays

6. Utilization review shall be performed by DMAS to determine if services are appropriately provided and to ensure that the services provided to Medicaid recipients are medically necessary and appropriate. Services not specifically documented in patients' medical records as having been rendered shall be deemed not to have been rendered and no reimbursement shall be provided.

7. All services furnished by a home health agency, whether provided directly by the agency or under arrangements with others, must be performed by appropriately qualified personnel. The following criteria shall apply to the provision of home health services:

a. Nursing services. Nursing services must be provided by a registered nurse or by a licensed practical nurse under the supervision of a graduate of an approved school of professional nursing and who is licensed as a registered nurse.

b. Home health aide services. Home health aides must meet the qualifications specified for home health aides by 42 CFR 484.36. Home health aide services may include assisting with personal hygiene, meal preparation and feeding, walking, and taking and recording blood pressure, pulse, and respiration. Home health aide services must be provided under the general supervision of a registered nurse. A recipient may not receive duplicative home health aide and personal care aide services.

c. Rehabilitation services. Services shall be specific and provide effective treatment for patients' conditions in accordance with accepted standards of medical practice. The amount, frequency, and duration of the services shall be reasonable. Rehabilitative services shall be provided with the expectation, based on the assessment made by physicians of patients' rehabilitation potential, that the condition of patients will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with the specific diagnosis.

(1) Physical therapy services shall be directly and specifically related to an active written care plan designed by a physician after any needed consultation with a physical therapist licensed by the Board of Medicine. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a physical therapist licensed by the Board of Medicine, or a physical therapy assistant who is licensed by the Board of Medicine and is under the direct supervision of a physical therapist licensed by the Board of Medicine. When physical therapy services are provided by a qualified physical therapy assistant, such services shall be provided under the supervision of a qualified physical therapist who makes an onsite supervisory visit at least once every 30 days. This visit shall not be reimbursable.

(2) Occupational therapy services shall be directly and specifically related to an active written care plan designed by a physician after any needed consultation with an occupational therapist registered and certified by the American Occupational Therapy Certification Board. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by an occupational therapist registered and certified by the American Occupational Therapy Certification Board, or an occupational therapy assistant who is certified by the American Occupational Therapy Certification Board under the direct supervision of an occupational therapist as defined above. When occupational therapy services are provided by a qualified occupational therapy assistant, such services shall be provided under the supervision of a qualified occupational therapist who makes an onsite supervisory visit at least once every 30 days. This visit shall not be reimbursable.

(3) Speech-language pathology services shall be directly and specifically related to an active written care plan designed by a physician after any needed consultation with a speech-language pathologist licensed by the Board of Audiology and Speech Pathology. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a speech-language pathologist licensed by the Board of Audiology and

Speech Pathology.

d. Durable medical equipment and supplies. Durable medical equipment, supplies, or appliances must be ordered by the physician, be related to the needs of the patient, and included on the plan of care. Treatment supplies used for treatment during the visit are included in the visit rate. Treatment supplies left in the home to maintain treatment after the visits shall be charged separately.

e. A visit shall be defined as the duration of time that a nurse, home health aide, or rehabilitation therapist is with a client to provide services prescribed by a physician and that are covered home health services. Visits shall not be defined in measurements or increments of time.

F. Optometrists' services are limited to examinations (refractions) after preauthorization by the state agency except for eyeglasses as a result of an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).

G. In the broad category of Special Services which includes nonemergency transportation, all such services for recipients will require preauthorization by a local health department.

H. Standards in other specialized high quality programs such as the program of Crippled Children's Services will be incorporated as appropriate.

I. Provisions will be made for obtaining recommended medical care and services regardless of geographic boundaries.

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PART I.
INTENSIVE PHYSICAL REHABILITATIVE SERVICES.

§ 1.1. A patient qualifies for intensive inpatient or outpatient rehabilitation if:

A. Adequate treatment of his medical condition requires an intensive rehabilitation program consisting of a multi-disciplinary coordinated team approach to improve his ability to function as independently as possible; and

B. It has been established that the rehabilitation program cannot be safely and adequately carried out in a less intense setting.

§ 1.2. In addition to the initial disability requirement, participants shall meet the following criteria:

A. Require at least two of the listed therapies in addition to rehabilitative nursing:

1. Occupational Therapy

2. Physical Therapy

3. Cognitive Rehabilitation

4. Speech-Language Therapy

B. Medical condition stable and compatible with an active rehabilitation program.

PART II.
INPATIENT ADMISSION AUTHORIZATION.

§ 2.1. Within 72 hours of a patient's admission to an intensive rehabilitation program, or within 72 hours of notification to the facility of the patient's Medicaid eligibility, the facility shall notify the Department of Medical Assistance Services in writing of the patient's admission. This notification shall include a description of the admitting diagnoses, plan of treatment, expected progress and a physician's certification that the patient meets the admission criteria. The Department of Medical Assistance Services will make a determination as to the appropriateness of the admission for Medicaid payment and notify the facility of its decision. If payment is approved, the Department will establish and notify the facility of an approved length of stay. Additional lengths of stay shall be reques ted in writing and approved by the Department. Admissions or lengths of stay not authorized by the Department of Medical Assistance Services will not be approved for payment.

PART III.
DOCUMENTATION REQUIREMENTS.

§ 3.1. Documentation of rehabilitation services shall, at a minimum:

A. Describe the clinical signs and symptoms of the patient necessitating admission to the rehabilitation program;

B. Describe any prior treatment and attempts to rehabilitate the patient;

C. Document an accurate and complete chronological picture of the patient's clinical course and progress in treatment;

D. Document that a multi-disciplinary coordinated treatment plan specifically designed for the patient has been developed;

E. Document in detail all treatment rendered to the patient in accordance with the plan with specific attention to frequency, duration, modality, response to treatment, and identify who provided such treatment;

F. Document each change in each of the patient's conditions;

G. Describe responses to and the outcome of treatment;

and

H. Describe a discharge plan which includes the anticipated improvements in functional levels, the time frames necessary to meet these goals, and the patient's discharge destination.

§ 3.2. Services not specifically documented in the patient's medical record as having been rendered will be deemed not to have been rendered and no reimbursement will be provided.

PART IV.
INPATIENT REHABILITATION EVALUATION.

§ 4.1. For a patient with a potential for physical rehabilitation for which an outpatient assessment cannot be adequately performed, an intensive evaluation of no more than seven calendar days will be allowed. A comprehensive assessment will be made of the patient's medical condition, functional limitations, prognosis, possible need for corrective surgery, attitude toward rehabilitation, and the existence of any social problems affecting rehabilitation. After these assessments have been made, the physician, in consultation with the rehabilitation team, shall determine and justify the level of care required to achieve the stated goals.

§ 4.2. If during a previous hospital stay an individual completed a rehabilitation program for essentially the same condition for which inpatient hospital care is now being considered, reimbursement for the evaluation will not be covered unless there is a justifiable intervening circumstance which necessitates a re-evaluation.

§ 4.3. Admissions for evaluation and/or training for solely vocational or educational purposes or for developmental or behavioral assessments are not covered services.

PART V.
CONTINUING EVALUATION.

§ 5.1. Team conferences shall be held as needed but at least every two weeks to assess and document the patient's progress or problems impeding progress. The team shall periodically assess the validity of the rehabilitation goals established at the time of the initial evaluation, and make appropriate adjustments in the rehabilitation goals and the prescribed treatment program. A review by the various team members of each others' notes does not constitute a team conference. A summary of the conferences, noting the team members present, shall be recorded in the clinical record and reflect the reassessments of the various contributors.

§ 5.2. Rehabilitation care is to be terminated, regardless of the approved length of stay, when further progress toward the established rehabilitation goal is unlikely or further rehabilitation can be achieved in a less intensive setting.

§ 5.3. Utilization review shall be performed to determine if services are appropriately provided and to ensure that the services provided to Medicaid recipients are medically necessary and appropriate. Services not specifically documented in the patient's medical record as having been rendered shall be deemed not to have been rendered and no reimbursment shall be provided.

PART VI.
THERAPEUTIC FURLOUGH DAYS.

§ 6.1. Properly documented medical reasons for furlough may be included as part of an overall rehabilitation program. Unoccupied beds (or days) resulting from an overnight therapeutic furlough will not be reimbursed by the Department of Medical Assistance Services.

PART VII.
DISCHARGE PLANNING.

§ 7.1. Discharge planning shall be an integral part of the overall treatment plan which is developed at the time of admission to the program. The plan shall identify the anticipated improvements in functional abilities and the probable discharge destination. The patient, unless unable to do so, or the responsible party shall participate in the discharge planning. Notations concerning changes in the discharge plan shall be entered into the record at least every two weeks, as a part of the team conference.

PART VIII.
REHABILITATION SERVICES TO PATIENTS.

§ 8.1. Rehabilitation services are medically prescribed treatment for improving or restoring functions which have been impaired by illness or injury or, where function has been permanently lost or reduced by illness or injury, to improve the individual's ability to perform those tasks required for independent functioning. The rules pertaining to them are:

A. Rehabilitative nursing.

Rehabilitative nursing requires education, training, or experience that provides special knowledge and clinical skills to diagnose nursing needs and treat individuals who have health problems characterized by alteration in cognitive and functional ability.

Rehabilitative nursing are those services furnished a patient which meet all of the following conditions:

1. The services shall be directly and specifically related to an active written treatment plan approved by a physician after any needed consultation with a registered nurse who is experienced in rehabilitation;

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a registered nurse or licensed professional nurse, nursing assistant, or rehabilitation technician under the

direct supervision of a registered nurse who is experienced in rehabilitation;

3. The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis; and

4. The service shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice and include the intensity of rehabilitative nursing services which can only be provided in an intensive rehabilitation setting.

B. Physical therapy.

Physical therapy services are those services furnished a patient which meet all of the following conditions:

1. The services shall be directly and specifically related to an active written treatment plan designed by a physician after any needed consultation with a physical therapist licensed by the Board of Medicine;

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a physical therapist licensed by the Board of Medicine, or a physical therapy assistant who is licensed by the Board of Medicine and under the direct supervision of a qualified physical therapist licensed by the Board of Medicine;

3. The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis; and

4. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency and duration of the services shall be reasonable.

C. Occupational therapy.

Occupational therapy services are those services furnished a patient which meet all of the following conditions:

1. The services shall be directly and specifically related to an active written treatment plan designed by the physician after any needed consultation with an occupational therapist registered and certified by the American Occupational Therapy Certification Board;

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature, that the services can only be performed by an occupational therapist registered and certified by the American Occupational Therapy Certification Board or an occupational therapy assistant certified by the American Occupational Therapy Certification Board under the direct supervision of a qualified occupational therapist as defined above;

3. The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis; and

4. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency and duration of the services shall be reasonable.

D. Speech-Language therapy.

Speech-Language therapy services are those services furnished a patient which meet all of the following conditions:

1. The services shall be directly and specifically related to an active written treatment plan designed by a physician after any needed consultation with a speech-language pathologist licensed by the Board of Audiology and Speech Pathology;

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a speech-language pathologist licensed by the Board of Audiology and Speech Pathology;

3. The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis; and

4. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency and duration of the services shall be reasonable.

E. Cognitive rehabilitation.

Cognitive rehabilitation services are those services furnished a patient which meet all of the following conditions:

1. The services shall be directly and specifically related to an active written treatment plan designed by the physician after any needed consultation with a clinical psychologist experienced in working with the neurologically impaired and licensed by the Board of Medicine;

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature, that the services can only be rendered after a neuropsychological evaluation administered by a clinical psychologist or physician experienced in the administration of neuropsychological assessments and licensed by the Board of Medicine and in accordance with a plan of care based on the findings of the neuropsychological evaluation;

3. Cognitive rehabiitation therapy services may be provided by occupational therapists, speech-language pathologists, and psychologists who have experience in working with the neurologically impaired when provided under a plan recommended and coordinated by a physician or clinical psychologist licensed by the Board of Medicine;

4. The cognitive rehabilitation services shall be an integrated part of the total patient care plan and shall relate to information processing deficits which are a consequence of and related to a neurologic event;

5. The services include activities to improve a variety of cognitive functions such as orientation, attention/concentration, reasoning, memory, discrimination and behavior; and

6. The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis.

F. Psychology.

Psychology services are those services furnished a patient which meet all of the following conditions:

1. The services shall be directly and specifically related to an active written treatment plan ordered by a physician;

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a qualified psychologist as required by state law;

3. The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis; and

4. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency and duration of the services shall be reasonable.

G. Social work.

Social work services are those services furnished a patient which meet all of the following conditions:

1. The services shall be directly and specifically related to an active written treatment plan ordered by a physician;

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a qualified social worker as required by state law;

3. The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis; and

4. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of practice; this includes the requirement that the amount, frequency and duration of the services shall be reasonable.

H. Recreational therapy.

Recreational therapy are those services furnished a patient which meet all of the following conditions:

1. The services shall be directly and specifically related to an active written treatment plan ordered by a physician;

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services are performed as an integrated part of a comprehensive rehabilitation plan of care by a recreation therapist certified with the

National Council for Therapeutic Recreation at the professional level;

3. The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis; and

4. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of practice; this includes the requirement that the amount, frequency and duration of the services shall be reasonable.

I. Prosthetic/orthotic services.

1. Prosthetic services furnished to a patient include prosthetic devices that replace all or part of an external body member, and services necessary to design the device, including measuring, fitting, and instructing the patient in its use;

2. Orthotic device services furnished to a patient include orthotic devices that support or align extremities to prevent or correct deformities, or to improve functioning, and services necessary to design the device, including measuring, fitting and instructing the patient in its use; and

3. Maxillofacial prosthetic and related dental services are those services that are specifically related to the improvement of oral function not to include routine oral and dental care.

4. The services shall be directly and specifically related to an active written treatment plan approved by a physician after consultation with a prosthetist, orthotist, or a licensed, board eligible prosthodontist, certified in Maxillofacial prosthetics.

5. The services shall be provided with the expectation, based on the assessment made by physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and predictable period of time, or shall be necessary to establish an improved functional state of maintenance.

6. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical and dental practice; this includes the requirement that the amount, frequency, and duration of the services be reasonable.

J. Durable medical equipment.

1. Durable medical equipment furnished the patient receiving approved covered rehabilitation services is covered when the equipment is necessary to carry out an approved plan of rehabilitation. A rehabilitation hospital or a rehabilitation unit of a hospital enrolled with Medicaid under a separate provider agreement for rehabilitative services may supply the durable medical equipment. The provision of the equipment is to be billed as an outpatient service. Medically necessary medical supplies, equipment and appliances shall be covered. Unusual amounts, types, and duration of usage must be authorized by DMAS in accordance with published policies and procedures. When determined to be cost-effective by DMAS, payment may be made for rental of the equipment in lieu of purchase. Payment shall not be made for additional equipment or supplies unless the extended provision of services has been authorized by DMAS. All durable medical equipment is subject to justification of need. Durable medical equipment normally supplied by the hospital for inpatient care is not covered by this provision.

2. Supplies, equipment, or appliances that are not covered for recipients of intensive physical rehabilitative services include, but are not limited to, the following:

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

b. Durable medical equipment and supplies for any hospital or nursing facility resident, except ventilators and associated supplies for nursing facility residents that have been approved by DMAS central office;

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

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

e. Items and services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member (for example, over-the-counter drugs; dentifrices; toilet articles; shampoos which do not require a physician's prescription; dental adhesives; electric toothbrushes;

cosmetic items, soaps, and lotions which do not require a physician's prescription; sugar and salt substitutes; support stockings; and non-legend drugs);

f. Home or vehicle modifications;

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

h. Equipment that the primary function is vocationally or educationally related (i.e., but not limited to, computers, environmental control devices, speech devices) environmental control devices, speech devices).

PART IX.
HOSPICE SERVICES.

§ 9.1. Admission criteria.

To be eligible for hospice coverage under Medicare or Medicaid, the and elect to receive hospice services rather than active treatment for the illness. Both the attending physician (if the individual has an attending physician) and the hospice medical director must certify the life expectancy.

§ 9.2. Utilization review.

Authorization for hospice services requires an initial preauthorization by DMAS and physician certification of life expectancy. Utilization review will be conducted to determine if services were provided by the appropriate provider and to ensure that the services provided to Medicaid recipients are medically necessary and appropriate. Services not specifically documented in the patients' medical records as having been rendered shall be deemed not to have been rendered and no coverage shall be provided.

§ 9.3. Hospice services are a medically directed, interdisciplinary program of palliative services for terminally ill people and their families, emphasizing pain and symptom control. The rules pertaining to them are:

1. Nursing care. Nursing care must be provided by a registered nurse or by a licensed practical nurse under the supervision of a graduate of an approved school of professional nursing and who is licensed as a registered nurse.

2. Medical social services. Medical social services must be provided by a social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education, and who is working under the direction of a physician.

3. Physician services. Physician services must be performed by a professional who is licensed to practice, who is acting within the scope of his license, and who is a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor. The hospice medical director or the physician member of the interdisciplinary team must be a licensed doctor of medicine or osteopathy.

4. Counseling services. Counseling services must be provided to the terminally ill individual and the family members or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training the individual's family or other caregiver to provide care, and for the purpose of helping the individual and those caring for him to adjust to the individual's approaching death. Bereavement counseling consists of counseling services provided to the individual's family up to one year after the individual's death. Bereavement counseling is a required hospice service, but it is not reimbursable.

5. Short-term inpatient care. Short-term inpatient care may be provided in a participating hospice inpatient unit, or a participating hospital or nursing facility. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management which cannot be provided in other settings. Inpatient care may also be furnished to provide respite for the individual's family or other persons caring for the individual at home.

6. Durable medical equipment and supplies. Durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness is covered. Medical supplies include those that are part of the written plan of care.

7. Drugs and biologicals. Only drugs which are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered.

8. Home health aide and homemaker services. Home health aides providing services to hospice recipients must meet the qualifications specified for home health aides by 42 CFR 484.36. Home health aides may provide personal care services. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient. Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment and services to enable the individual to carry out the plan of care. Home health aide and homemaker services must be provided under the general supervision of a registered nurse.

9. Rehabilitation services. Rehabilitation services include physical and occupational therapies and

speech-language pathology services that are used for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

PART X.
COMMUNITY MENTAL HEALTH SERVICES.

§ 10.1. Utilization review general requirements.

A. On-site utilization reviews shall be conducted, at a minimum annually at each enrolled provider, by the state Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS). During each on-site review, an appropriate sample of the provider's total Medicaid population will be selected for review. An expanded review shall be conducted if an appropriate number of exceptions or problems are identified.

B. The DMHMRSAS review shall include the following items:

1. Medical or clinical necessity of the delivered service;

2. The admission to service and level of care was appropriate;

3. The services were provided by appropriately qualified individuals as defined in the Amount, Duration, and Scope of Services found in Attachment 3.1 A and B, Supplement 1 § 13d Rehabilitative Services; and

4. Delivered services as documented are consistent with recipients' Individual Service Plans, invoices submitted, and specified service limitations.

§ 10.2. Mental health services utilization criteria.

Utilization reviews shall include determinations that providers meet all the requirements of Virginia state regulations found at VR 460-03-3.1100.

A. Intensive in-home services for children and adolescents.

1. At admission, an appropriate assessment is made and documented that service needs can best be met through intervention provided [typically but not solely] in the client's residence; service [~~must~~ shall] be recommended in the Individual Service Plan (ISP) [which shall be fully completed within 30 days of initiation of services] .

2. Services [~~must~~ shall] be delivered primarily in the family's residence. Some services may be delivered while accompanying family members to community agencies or in other locations.

3. Services shall be used when out-of-home placement is a risk and when services that are far more intensive than outpatient clinic care are required to stabilize the family situation, and when the client's residence as the setting for services is more likely to be successful than a clinic.

4. Services are not appropriate for a family in which a child has run away or a family for which the goal is to keep the family together only until an out-of-home placement can be arranged.

5. 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.

6. At least one parent or responsible adult with whom the child is living must be willing to participate in in-home services, with the goal of keeping the child with the family.

7. The provider of intensive in-home services for children and adolescents [~~must~~ shall] be licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services.

8. The billing unit for intensive in-home service is one hour. Although the pattern of service delivery may vary, in-home service is an intensive service provided to individuals for whom there is a plan of care in effect which demonstrates the need for a minimum of five hours a week of intensive in-home service, and includes a plan for service provision of a minimum of five hours of service delivery per client/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 and family initially with a lessening or tapering off of intensity toward the latter weeks of service. Intensive in-home services below the five-hour a week minimum may be covered. However, variations in this pattern must be consistent with the individual service plan. Service plans must incorporate a discharge plan which identifies transition from intensive in-home to less intensive or nonhome based services.

9. The intensity of service dictates that caseload sizes should be six or fewer cases at any given time. If on review caseloads exceed this limit, the provider will be required to submit a corrective action plan designed to reduce caseload size to the required limit unless the provider can demonstrate that enough of the cases in the caseload are moving toward discharge so that the caseload standard will be met within three months by attrition. Failure to maintain required caseload sizes in two or more review periods may result in termination of the provider agreement unless the provider demonstrates the ability to attain and maintain the required caseload size.

10. Emergency assistance shall be available 24 hours

per day, seven days a week.

B. Therapeutic day treatment for children and adolescents.

1. Therapeutic day treatment is appropriate for children and adolescents who meet the DMHMRSAS definitions of "serious emotional disturbance" or "at risk of developing serious emotional disturbance" and who also meet one of the following:

a. Children and adolescents who require year-round treatment in order to sustain behavioral 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 have deficits in social skills, peer relations, dealing with authority; are hyperactive; have poor impulse control; 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.

2. The provider of therapeutic day treatment for child and adolescent services [~~must~~ shall] be licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services.

3. The minimum staff-to-youth ratio shall ensure that adequate staff is available to meet the needs of the youth identified on the ISP.

4. 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 defined as a minimum of two hours but less than three hours in a given day. Two units of service are defined as a minimum of three but less than five hours in a given day; and three units of service equals five or more hours of service. Transportation time to and from the program site may be included as part of the reimbursable unit. However, transportation time exceeding 25% of the total daily time spent in the service for each individual shall not be billable. These restrictions apply only to transportation to and from the program site. Other program-related transportation may be included in the program day as indicated by scheduled activities.

5. Time for academic instruction when no treatment activity is going on cannot be included in the billing unit.

6. Services shall be provided following a diagnostic assessment when authorized by the physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker or certified psychiatric nurse and in accordance with an ISP [which shall be fully completed within 30 days of initiation of the service] .

C. Day treatment/partial hospitalization services shall be provided to adults with serious mental illness following diagnostic assessment when authorized by the physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, or certified psychiatric nurse [: ~~The service may be initiated without an Individual Service Plan (ISP) modification or goal in a crisis situation. When this occurs, an ISP must be completed within 10 working days of service initiation~~ , and in accordance with an ISP which shall be fully completed within 30 days of service initiation] .

1. The provider of day treatment/partial hospitalization shall be licensed by DMHMRSAS.

2. The program [~~must~~ shall] operate a minimum of two continuous hours in a 24-hour period. 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. Transportation time to and from the program site may be included as part of the reimbursable unit. However, transportation time exceeding 25% of the total daily time spent in the service for each individual shall not be covered. These restrictions shall apply only to transportation to and from the program site. Other program-related transportation may be included in the program day as indicated by scheduled program activities.

3. Individuals shall be discharged from this service when they are no longer in an acute psychiatric state or when other less intensive services may achieve stabilization. Admission and services longer than 90 calendar days must be authorized based upon a face-to-face evaluation by a physician, licensed clinical psycholo gist, licensed professional counselor, licensed clinical social worker, or certified psychiatric nurse.

D. Psychosocial rehabilitation services shall be provided to those individuals who have mental illness or mental retardation, and who have experienced long-term or repeated psychiatric hospitalization, or who lack daily living skills 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 care is needed to maintain the individual in the community.

[1. Services shall be provided following an assessment which clearly documents the need for services and in accordance with an ISP which shall be fully completed within 30 days of service initiation.]

[~~1.~~ 2.] The provider of psychosocial rehabilitation [~~must~~ shall] be licensed by DMHMRSAS.

[~~2.~~ 3.] The program [~~must~~ shall] operate a minimum of two continuous hours in a 24-hour period. 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. Transportation time to and from the program site may be included as part of the reimbursement unit. However, transportation time exceeding 25% of the total daily time spent in the service for each individual shall not be covered. These restrictions apply only to transportation to and from the program site. Other program-related transportation may be included in the program day as indicated by scheduled program activities.

[~~3.~~ 4.] 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 understanding or ability to access community resources.

E. Admission to crisis intervention services is indicated following a marked reduction in the individual's psychiatric, adaptive or behavioral functioning or an extreme increase in personal distress. Crisis intervention may be the initial contact with a client.

1. The provider of crisis intervention services [~~must~~ shall] be licensed as an Outpatient Program by DMHMRSAS.

2. Client-related activities provided in association with a face-to-face contact are reimbursable.

3. An 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 be developed or revised 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. [When travel is required to provide out-of-clinic services, such time is reimbursable.] Crisis intervention may involve the family or significant others.

F. Case management.

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 in effect which requires regular direct or client-related contacts or activity or communication with the client or families, [significant others,] service providers, [~~significant others~~] and others including a minimum of one face-to-face client 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 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.

4. The ISP must document the need for case management [and be fully completed within 30 days of initiation of the service] , and the case manager [~~must~~ shall] review the ISP 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 ~~must~~ shall be updated at least annually.]

§ 10.3. Mental retardation utilization criteria.

Utilization reviews shall include determinations that providers meet all the requirements of Virginia state regulations found at VR 460-03-3.1100.

A. Appropriate use of day health and rehabilitation services requires the following conditions [~~*must*~~ *shall*] *be met:*

1. The service is provided by a program with an operational focus on skills development, social learning and interaction, support, and supervision.

2. The individual shall be assessed and deficits must be found in two or more of the following areas to qualify for services:

a. Managing personal care needs,

b. Understanding verbal commands and communicating needs and wants,

c. Earning wages without intensive, frequent and ongoing supervision or support,

d. Learning new skills without planned and consistent or specialized training and applying skills learned in a training situation to other environments,

e. Exhibiting behavior appropriate to time, place and situation that is not threatening or harmful to the health or safety of self or others without direct supervision,

f. Making decisions which require informed consent,

g. Caring for other needs without the assistance or personnel trained to teach functional skills,

h. Functioning in community and integrated environments without structured, intensive and frequent assistance, supervision or support.

3. Services for the individual [~~*must*~~ *shall*] *be preauthorized* [~~*every six months*~~ *annually*] *by DMHMRSAS.*

4. Each individual [~~*must*~~ *shall*] *have a written plan of care developed by the provider* [*which shall be fully complete within 30 days of initiation of the service*] , *with a review of the plan of care at least every 90 days with modification as appropriate. A 10-day grace period is allowable.*

5. The provider [~~*must*~~ *shall*] *update the plan of care* [*at least*] *annually.*

6. The individual's record [~~*must*~~ *shall*] *contain adequate documentation concerning progress or lack thereof in meeting plan of care goals.*

7. The program [~~*must*~~ *shall*] *operate a minimum of two continuous hours in a 24-hour period. 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 at least four but less than seven hours on a given day. Three units of service shall be defined as seven or more hours in a given day. Transportation time to and from the program site may be included as part of the reimbursable unit. However, transportation time exceeding 25% of the total daily time spent in the service for each individual shall not be covered. These restrictions shall apply only to transportation to and from the program site. Other program-related transportation may be included in the program day as indicated by scheduled program activities.*

8. The provider [~~*must*~~ *shall*] *be licensed by DMHMRSAS.*

B. Appropriate use of case management services for [~~*mentally retarded*~~] *persons* [*with mental retardation*] *requires the following conditions to be met:*

1. The individual must require case management as documented on the consumer service plan of care which is developed based on appropriate assessment and supporting data. Authorization for case management services [~~*must*~~ *shall*] *be obtained from DMHMRSAS Care Coordination Unit* [~~*every six months*~~ *annually*] .

2. An active client shall be defined as an individual for whom there is a plan of care in effect which requires regular direct or client-related contacts or communication or activity with the client, family, service providers, significant others and other entities including a minimum of one face-to-face contact within a 90-day period.

3. The plan of care shall address the individual's needs in all life areas with consideration of the individual's age, primary disability, level of functioning and other relevant factors.

a. The plan of care shall be reviewed by the case manager every three months to ensure the identified needs are met and the required services are provided. 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 given up to the last day of the fourth month following the month of the prior 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 the actual review.

b. The need for case management services shall be

assessed and justified through the development of an annual consumer service plan. [~~*Continued service justification shall be documented at the six-month review.*~~]

4. The individual's record [~~*must*~~ *shall*] *contain adequate documentation concerning progress or lack thereof in meeting the consumer service plan goals.*

PART XI.
GENERAL OUTPATIENT PHYSICAL REHABILITATION SERVICES.

§ 11.1. Scope.

A. Medicaid covers general outpatient physical rehabilitative services provided in outpatient settings of acute and rehabilitation hospitals and by rehabilitation agencies which have a provider agreement with the Department of Medical Assistance Services (DMAS).

B. Outpatient rehabilitative services shall be prescribed by a physician and be part of a written plan of care.

§ 11.2. Covered outpatient rehabilitative services.

Covered outpatient rehabilitative services shall include physical therapy, occupational therapy, and speech-language pathology services. Any one of these services may be offered as the sole rehabilitative service and shall not be contingent upon the provision of another service.

§ 11.3. Eligibility criteria for outpatient rehabilitative services.

To be eligible for general outpatient rehabilitative services, the patient must require at least one of the following services: physical therapy, occupational therapy, speech-language pathology services, and respiratory therapy. All rehabilitative services must be prescribed by a physician.

§ 11.4. Criteria for the provision of outpatient rehabilitative services.

All practitioners and providers of services shall be required to meet state and federal licensing and/or certification requirements.

A. Physical therapy services meeting all of the following conditions shall be furnished to patients:

1. Physical therapy services shall be directly and specifically related to an active written care plan designed by a physician after any needed consultation with a physical therapist licensed by the Board of Medicine.

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a physical therapist licensed by the Board of Medicine, or a physical therapy assistant who is licensed by the Board of Medicine and is under the direct supervision of a physical therapist licensed by the Board of Medicine. When physical therapy services are provided by a qualified physical therapy assistant, such services shall be provided under the supervision of a qualified physical therapist who makes an onsite supervisory visit at least once every 30 days. This visit shall not be reimbursable.

3. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services shall be reasonable.

B. Occupational therapy services shall be those services furnished a patient which meet all of the following conditions:

1. Occupational therapy services shall be directly and specifically related to an active written care plan designed by a physician after any needed consultation with an occupational therapist registered and certified by the American Occupational Therapy Certification Board.

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by an occupational therapist registered and certified by the American Occupational Therapy Certification Board, a graduate of a program approved by the Council on Medical Education of the American Medical Association and engaged in the supplemental clinical experience required before registration by the American Occupational Therapy Association when under the supervision of an occupational therapist defined above, or an occupational therapy assistant who is certified by the American Occupational Therapy Certification Board under the direct supervision of an occupational therapist as defined above. When occupational therapy services are provided by a qualified occupational therapy assistant or a graduate engaged in supplemental clinical experience required before registration, such services shall be provided under the supervision of a qualified occupational therapist who makes an onsite supervisory visit at least once every 30 days. This visit shall not be reimbursable.

3. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services shall be reasonable.

C. Speech-language pathology services shall be those services furnished a patient which meet all of the

following conditions:

1. The services shall be directly and specifically related to an active written treatment plan designed by a physician after any needed consultation with a speech-language pathologist licensed by the Board of Audiology and Speech Pathology, or, if exempted from licensure by statute, meeting the requirements in 42 CFR 440 110(c);

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by or under the direction of a speech-language pathologist who meets the qualifications in Subdivision B1 above. The program must meet the requirements of 42 CFR 405.1719(c). At least one qualified speech-language pathologist must be present at all times when speech-language pathology services are rendered; and

3. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services shall be reasonable.

§ 11.5. Authorization for services.

A. General physical rehabilitative services provided in outpatient settings of acute and rehabilitation hospitals and by rehabilitation agencies shall include authorization for up to 24 visits by each ordered rehabilitative service within a 60-day period. A recipient may receive a maximum of 48 visits annually without authorization. The provider shall maintain documentation to justify the need for services. A visit shall be defined as the duration of time that a rehabilitative therapist is with a client to provide services prescribed by the physician. Visits shall not be defined in measurements or increments of time.

B. The provider shall request from DMAS authorization for treatments deemed necessary by a physician beyond the number authorized by using the Rehabilitation Treatment Authorization form (DMAS-125). This request must be signed and dated by a physician. Authorization for extended services shall be based on individual need. Payment shall not be made for additional service unless the extended provision of services has been authorized by DMAS. Periods of care beyond those allowed which have not been authorized by DMAS shall not be approved for payment.

§ 11.6. Documentation requirements.

A. Documentation of general outpatient rehabilitative services provided by a hospital-based outpatient setting or a rehabilitation agency shall, at a minimum:

1. describe the clinical signs and symptoms of the patient's condition;

2. include an accurate and complete chronological picture of the patient's clinical course and treatments;

3. document that a plan of care specifically designed for the patient has been developed based upon a comprehensive assessment of the patient's needs;

4. include a copy of the physician's orders and plan of care;

5. include all treatment rendered to the patient in accordance with the plan with specific attention to frequency, duration, modality, response, and identify who provided care (include full name and title);

6. describe changes in each patient's condition and response to the rehabilitative treatment plan; and

7. describe a discharge plan which includes the anticipated improvements in functional levels, the time frames necessary to meet these goals, and the patient's discharge destination.

B. Services not specifically documented in the patient's medical record as having been rendered shall be deemed not to have been rendered and no coverage shall be provided.

§ 11.7. Service limitations.

The following general conditions shall apply to reimbursable physical rehabilitative services:

A. Patient must be under the care of a physician who is legally authorized to practice and who is acting within the scope of his license.

B. Services shall be furnished under a written plan of treatment and must be established and periodically reviewed by a physician. The requested services or items must be necessary to carry out the plan of treatment and must be related to the patient's condition.

C. A physician recertification shall be required periodically, must be signed and dated by the physician who reviews the plan of treatment, and may be obtained when the plan of treatment is reviewed. The physician recertification statement must indicate the continuing need for services and should estimate how long rehabilitative services will be needed.

D. The physician orders for therapy services shall include the specific procedures and modalities to be used, identify the specific discipline to carry out the plan of care, and indicate the frequency and duration for services.

E. Utilization review shall be performed to determine if services are appropriately provided and to ensure that the services provided to Medicaid recipients are medically necessary and appropriate. Services not specifically documented in the patient's medical record as having been

rendered shall be deemed not to have been rendered and no coverage shall be provided.

F. Rehabilitation care is to be terminated regardless of the approved length of stay when further progress toward the established rehabilitation goal is unlikely or when the services can be provided.

VR 460-02-4.1920. Methods and Standards for Establishing Payment Rates–Other Types of Care.

The policy and the method to be used in establishing payment rates for each type of care or service (other than inpatient hospitalization, skilled nursing and intermediate care facilities) listed in § 1905(a) of the Social Security Act and included in this State Plan for Medical Assistance are described in the following paragraphs:

a. Reimbursement and payment criteria will be established which are designed to enlist participation of a sufficient number of providers of services in the program so that eligible persons can receive the medical care and services included in the Plan at least to the extent these are available to the general population.

b. Participation in the program will be limited to providers of services who accept, as payment in full, the state's payment plus any copayment required under the State Plan.

c. Payment for care or service will not exceed the amounts indicated to be reimbursed in accord with the policy and methods described in this Plan and payments will not be made in excess of the upper limits described in 42 CFR 447.304(a). The state agency has continuing access to data identifying the maximum charges allowed: such data will be made available to the Secretary, HHS, upon request.

d. Payments for services listed below shall be on the basis of reasonable cost following the standards and principles applicable to the Title XVIII Program. 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.

Reasonable costs will be determined from the filing of a uniform cost report by participating providers. The cost reports are due not later than 90 days after the provider's fiscal year end. If a complete cost report is not received within 90 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 which 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.

Item 398 D of the 1987 Appropriation Act, as amended, effective April 8, 1987, eliminated reimbursement of return on equity capital to proprietary providers.

The services that are cost reimbursed are:

(1) Inpatient hospital services to persons over 65 years of age in tuberculosis and mental disease hospitals

(2) Home health care services

(3) Outpatient hospital services excluding laboratory

(4) Rural health clinic services provided by rural health clinics or other federally qualified health centers defined as eligible to receive grants under the Public Health Services Act §§ 329, 330, and 340.

(5) Rehabilitation agencies

(6) Comprehensive outpatient rehabilitation facilities

(7) Rehabilitation hospital outpatient services.

e. Fee-for-service providers. (1) Payment for the following services shall be the lowest of: State agency fee schedule, actual charge (charge to the general public), or Medicare (Title XVIII) allowances:

(a) Physicians' services (Supplement 1 has obstetric/pediatric fees.)

(b) Dentists' services

(c) Mental health services including:

Community mental health services

Services of a licensed clinical psychologist

Mental health services provided by a physician

(d) Podiatry

(e) Nurse-midwife services

(f) Durable medical equipment

(g) Local health services

(h) Laboratory services (Other than inpatient hospital)

(i) Payments to physicians who handle laboratory specimens, but do not perform laboratory analysis (limited to payment for handling)

(j) X-Ray services

(k) Optometry services

(l) Medical supplies and equipment.

(2) Hospice services payments must be no lower than the amounts using the same methodology used under part A of Title XVIII, and adjusted to disregard offsets attributable to Medicare coinsurance amounts.

f. Payment for pharmacy services shall be the lowest of items (1) through (5) (except that items (1) and (2) will not apply when prescriptions are certified as brand necessary by the prescribing physician in accordance with the procedures set forth in 42 CFR 447.331 (c) if the brand cost is greater than the HCFA upper limit of VMAC cost) subject to the conditions, where applicable, set forth in items (6) and (7) below:

(1) The upper limit established by the Health Care Financing Administration (HCFA) for multiple source drugs pursuant to 42 CFR §§ 447.331 and 447.332, as determined by the HCFA 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 Virginia Maximum Allowable Cost (VMAC) established by the agency plus a dispensing fee, if a legend drug, for multiple source drugs listed on the VVF.

(3) The Estimated Acquisition Cost (EAC) which shall be based on the published Average Wholesale Price (AWP) minus a percent discount established by the methodology set out in (a) through (c) below. (Pursuant to OBRA 90 § 4401, from January 1, 1991, through December 31, 1994, no changes in reimbursement limits or dispensing fees shall be made which reduce such limits or fees for covered outpatient drugs).

(a) Percent 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, but no less frequently than triennially.

(4) A mark-up allowance (150%) of the Estimated Acquisition Cost (EAC) for covered nonlegend drugs and oral contraceptives.

(5) The provider's usual and customary charge to the public, as identified by the claim charge.

(6) Payment for pharmacy services will be as described above; however, payments for legend drugs (except oral contraceptives) will include the allowed cost of the drug plus only one dispensing fee per month for each specific drug. Payments will be reduced by the amount of the established copayment per prescription by noninstitutionalized clients with exceptions as provided in federal law and regulation.

(7) The Program recognizes the unit dose delivery system of dispensing drugs only for patients residing in nursing facilities. Reimbursements are based on the allowed payments described above plus the unit dose add on fee and an allowance for the cost of unit dose packaging established by the state agency. The maximum allowed drug cost for specific multiple source drugs will be the lesser of: either the VMAC based on the 60th percentile cost level identified by the state agency or HCFA's upper limits. All other drugs will be reimbursed at drug costs not to exceed the estimated acquisition cost determined by the state agency.

(8) Historical determination of EAC. Determination of EAC was the result of an analysis of FY'89 paid claims data of ingredient cost used to develop a matrix of cost using 0 to 10% reductions from AWP as well as discussions with pharmacy providers. As a result of this analysis, AWP minus 9.0% was determined to represent prices currently paid by providers effective October 1, 1990.

The same methodology used to determine AWP minus 9.0% was utilized to determine a dispensing fee of $4.40 per prescription as of October 1, 1990. A periodic review of dispensing fee using Employment Cost Index - wages and salaries, professional and technical workers will be done with changes made in dispensing fee when appropriate. As of October 1, 1990, the Estimated Acquisition Cost will be AWP minus 9.0% and dispensing fee will be $4.40.

g. All reasonable measures will be taken to ascertain the legal liability of third parties to pay for authorized care and services provided to eligible recipients including those measures specified under 42 USC 1396(a)(25).

h. The single state agency will take whatever measures are necessary to assure appropriate audit of records whenever reimbursement is based on costs of providing care and services, or on a fee-for-service plus cost of materials.

i. Payment for transportation services shall be according to the following table:

TYPE OF SERVICE	PAYMENT METHODOLOGY
Taxi services	Rate set by the single state agency
Wheelchair van	Rate set by the single state agency
Nonemergency ambulance	Rate set by the single state agency
Emergency ambulance	Rate set by the single state agency
Volunteer drivers	Rate set by the single state agency
Air ambulance	Rate set by the single state agency
Mass transit	Rate charged to the public
Transportation agreements	Rate set by the single state agency
Special Emergency transportation	Rate set by the single state agency

j. Payments for Medicare coinsurance and deductibles for noninstitutional services shall not exceed the allowed charges determined by Medicare in accordance with 42 CFR 447.304(b) less the portion paid by Medicare, other third party payors, and recipient copayment requirements of this Plan. See Supplement 2 for this methodology.

k. Payment for eyeglasses shall be the actual cost of the frames and lenses not to exceed limits set by the single state agency, plus a dispensing fee not to exceed limits set by the single state agency.

l. Expanded prenatal care services to include patient education, homemaker, and nutritional services shall be reimbursed at the lowest of: state agency fee schedule, actual charge, or Medicare (Title XVIII) allowances.

m. Targeted case management for high-risk pregnant women and infants up to age ~~1~~ *2 and for community mental health and mental retardation services* shall be reimbursed at the lowest of: state agency fee schedule, actual charge, or Medicare (Title XVIII) allowances.

n. Reimbursement for all other nonenrolled institutional and noninstitutional providers.

(1) All other nonenrolled providers shall be reimbursed the lesser of the charges submitted, the DMAS cost to charge ratio, or the Medicare limits for the services provided.

(2) Outpatient hospitals that are not enrolled as providers with the Department of Medical Assistance Services (DMAS) which submit claims shall be paid based on the DMAS average reimbursable outpatient cost-to-charge ratio, updated annually, for enrolled outpatient hospitals less five percent. The five percent is for the cost of the additional manual processing of the claims. Outpatient hospitals that are nonenrolled shall submit claims on DMAS invoices.

(3) Nonenrolled providers of noninstitutional services shall be paid on the same basis as enrolled in-state providers of noninstitutional services. Nonenrolled providers of physician, dental, podiatry, optometry, and clinical psychology services, etc., shall be reimbursed the lesser of the charges submitted, or the DMAS rates for the services.

(4) All nonenrolled noninstitutional providers shall be reviewed every two years for the number of Medicaid recipients they have served. Those providers who have had no claims submitted in the past twelve months shall be declared inactive.

(5) Nothing in this regulation is intended to preclude DMAS from reimbursing for special services, such as rehabilitation, ventilator, and transplantation, on an exception basis and reimbursing for these services on an individually, negotiated rate basis.

o. Refund of overpayments.

(1) Providers reimbursed on the basis of a fee plus cost of materials.

(a) When DMAS determines an overpayment has been made to a provider, DMAS shall promptly send the first demand letter requesting a lump sum refund. Recovery shall be undertaken even though the provider disputes in whole or in part DMAS's determination of the overpayment.

(b) If the provider cannot refund the total amount of the overpayment within 30 days after receiving the DMAS demand letter, the provider shall promptly request an extended repayment schedule.

DMAS may establish a repayment schedule of up to 12 months to recover all or part of an overpayment or, if a provider demonstrates that repayment within a 12-month period would create severe financial

hardship, the Director of the Department of Medical Assistance Services (the "director") may approve a repayment schedule of up to 36 months.

A provider shall have no more than one extended repayment schedule in place at one time. If an audit later uncovers an additional overpayment, the full amount shall be repaid within 30 days unless the provider submits further documentation supporting a modification to the existing extended repayment schedule to include the additional amount.

If, during the time an extended repayment schedule is in effect, the provider withdraws from the Program, the outstanding balance shall become immediately due and payable.

When a repayment schedule is used to recover only part of an overpayment, the remaining amount shall be recovered by the reduction of interim payments to the provider or by lump sum payments.

(c) In the request for an extended repayment schedule, the provider shall document the need for an extended (beyond 30 days) repayment and submit a written proposal scheduling the dates and amounts of repayments. If DMAS approves the schedule, DMAS shall send the provider written notification of the approved repayment schedule, which shall be effective retroactive to the date the provider submitted the proposal.

(d) Once an initial determination of overpayment has been made, DMAS shall undertake full recovery of such overpayment whether the provider disputes, in whole or in part, the initial determination of overpayment. If an appeal follows, interest shall be waived during the period of administrative appeal of an initial determination of overpayment.

Interest charges on the unpaid balance of any overpayment shall accrue pursuant to § 32.1-313 of the Code of Virginia from the date the director's determination becomes final.

The director's determination shall be deemed to be final on (i) the issue date of any notice of overpayment, issued by DMAS, if the provider does not file an appeal, or (ii) the issue date factfinding conference, if the provider does not file an appeal, or (iii) the issue date of any administrative decision signed by the director, regardless of whether a judicial appeal follows. In any event, interest shall be waived if the overpayment is completely liquidated within 30 days of the date of the final determination. In cases in which a determination of overpayment has been judicially reversed, the provider shall be reimbursed that portion of the payment to which it is entitled, plus any applicable interest which the provider paid to DMAS.

(2) Providers reimbursed on the basis of reasonable costs.

(a) When the provider files a cost report indicating that an overpayment has occurred, full refund shall be remitted with the cost report. In cases where DMAS discovers an overpayment during desk review, field audit, or final settlement, DMAS shall promptly send the first demand letter requesting a lump sum refund. Recovery shall be undertaken even though the provider disputes in whole or in part DMAS's determination of the overpayment.

(b) If the provider has been overpaid for a particular fiscal year and has been underpaid for another fiscal year, the underpayment shall be offset against the overpayment. So long as the provider has an overpayment balance, any underpayments discovered by subsequent review or audit shall also be used to reduce the remaining amount of the overpayment.

(c) If the provider cannot refund the total amount of the overpayment (i) at the time it files a cost report indicating that an overpayment has occurred, the provider shall request an extended repayment schedule at the time of filing, or (ii) within 30 days after receiving the DMAS demand letter, the provider shall promptly request an extended repayment schedule.

DMAS may establish a repayment schedule of up to 12 months to recover all or part of an overpayment or, if a provider demonstrates that repayment within a 12-month period would create severe financial hardship, the Director of the Department of Medical Assistance Services (the "director") may approve a repayment schedule of up to 36 months.

A provider shall have no more than one extended repayment schedule in place at one time. If an audit later uncovers an additional overpayment, the full amount shall be repaid within 30 days unless the provider submits further documentation supporting a modification to the existing extended repayment schedule to include the additional amount.

If, during the time an extended repayment schedule is in effect, the provider withdraws from the Program or fails to file a cost report in a timely manner, the outstanding balance shall become immediately due and payable.

When a repayment schedule is used to recover only part of an overpayment, the remaining amount shall be recovered by the reduction of interim payments to the provider or by lump sum payments.

(d) In the request for an extended repayment schedule, the provider shall document the need for

an extended (beyond 30 days) repayment and submit a written proposal scheduling the dates and amounts of repayments. If DMAS approves the schedule, DMAS shall send the provider written notification of the approved repayment schedule, which shall be effective retroactive to the date the provider submitted the proposal.

(e) Once an initial determination of overpayment has been made, DMAS shall undertake full recovery of such overpayment whether or not the provider disputes, in whole or in part, the initial determination of overpayment. If an appeal follows, interest shall be waived during the period of administrative appeal of an initial determination of overpayment.

Interest charges on the unpaid balance of any overpayment shall accrue pursuant to § 32.1-313 of the Code of Virginia from the date the director's determination becomes final.

The director's determination shall be deemed to be final on (i) the due date of any cost report filed by the provider indicating that an overpayment has occurred, or (ii) the issue date of any notice of overpayment, issued by DMAS, if the provider does not file an appeal, or (iii) the issue date of any administrative decision issued by DMAS after an informal factfinding conference, if the provider does not file an appeal, or (iv) the issue date of any administrative decision signed by the director, regardless of whether a judicial appeal follows. In any event, interest shall be waived if the overpayment is completely liquidated within 30 days of the date of the final determination. In cases in which a determination of overpayment has been judicially reversed, the provider shall be reimbursed that portion of the payment to which it is entitled, plus any applicable interest which the provider paid to DMAS.

VR 460-04-8.1500. Community Mental Health and Mental Retardation Services: Amount, Duration, and Scope of Services.

§ 1. Definitions.

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

"Board" or "BMAS" means the Board of Medical Assistance Services.

"Code" means the Code of Virginia.

"Consumer service plan" means that document addressing the needs of the client of mental retardation case management services, in all life areas. Factors to be considered when this plan is developed are, but not limited to, the client's age, primary disability, level of functioning and other relevant factors.

"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.

"DMHMRSAS" means the Department of Mental Health, Mental Retardation and Substance Abuse Services consistent with Chapter 1 (§ 37.1-39 et seq.) of Title 37 of the Code of Virginia.

"Developmental disability" means a severe, chronic disability that (i) is attributable to a mental or physical impairment (attributable to mental retardation, cerebral palsy, epilepsy, autism, or neurological impairment or related conditions) or combination of mental and physical impairments; (ii) is manifested before that person attains the age of 22; (iii) is likely to continue indefinitely; (iv) results in substantial functional limitations in three or more of the following major areas: self-care, language, learning, mobility, self-direction, capacity for independent living and economic self-sufficiency; and (v) results in the person's need for special care, treatment or services that are individually planned and coordinated and that are of lifelong or extended duration.

"HCFA" means the Health Care Financing Administration as that unit of the federal Department of Health and Human Services which administers the Medicare and Medicaid programs.

"Individual Service Plan" or "ISP" means that which is defined in DMHMRSAS licensing regulations VR 470-02-09.

"Medical or clinical necessity" means an item or service that must be consistent with the diagnosis or treatment of the individual's condition. It must be in accordance with the community standards of medical or clinical practice.

"Mental retardation" means the diagnostic classification of substantial subaverage general intellectual functioning which originates during the development period and is associated with impairment in adaptive behavior.

"Preauthorization" means the approval by the care coordinator of the plan of care which specifies recipient and provider. Preauthorization is required before reimbursement can be made.

"Qualified case managers for mental health case management services" means individuals possessing a combination of mental health work experience or relevant education which indicates that the individual possesses the knowledge, skills, and abilities, as established by DMHMRSAS, necessary to perform case management services.

"Qualified case managers for mental retardation case management services" means individuals possessing a combination of mental retardation work experience and

relevant education which indicates that the individual possesses the knowledge, skills, and abilities, as established by DMHMRSAS, necessary to perform case management services.

"Significant others" means persons related to or interested in the individual's health, well-being, and care. Significant others may be, but are not limited, to a spouse, friend, relative, guardian, priest, minister, rabbi, physician, neighbor.

"State Plan for Medical Assistance" or "Plan" means the document listing the covered groups, covered services and their limitations, and provider reimbursement methodologies as provided for under Title XIX of the Social Security Act.

§ 2. Mental health services.

The following services shall be covered: intensive in-home services, therapeutic day treatment for children and adolescents, day treatment/partial hospitalization, psychosocial rehabilitation, and crisis intervention. These covered services are further defined below:

A. Intensive in-home services for children and adolescents under age 21 shall be time-limited interventions provided typically but not solely in the residence of an individual who is at risk of being moved into an out-of-home placement or who is being transitioned to home from out-of-home placement due to a disorder diagnosable under the Diagnostic and Statistical Manual of Mental Disorders-III-R (DSM-III-R). These services provide crisis treatment; individual and family counseling; life, parenting, and communication skills; case management activities and coordination with other required services; and 24-hour emergency response. These services shall be limited annually to 26 weeks. General program requirements shall be as follows:

1. The provider of intensive in-home services [~~must~~ shall] be licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services.

2. An appropriate assessment is made and documented that service needs can best be met through intensive in-home services; service [~~must~~ shall] be recommended on an Individual Service Plan (ISP).

3. Intensive in-home services shall be used when out-of-home placement is a risk, when services that are far more intensive than outpatient clinic care are required to stabilize the family situation, and when the client's residence as the setting for services is more likely to be successful than a clinic.

4. Intensive in-home services shall also be used to facilitate the return from an out-of-home placement when services more intensive than outpatient clinic care are required for the transition to be successful.

5. At least one parent or responsible adult with whom the child is living must be willing to participate in in-home services.

6. Since case management services are an integral and inseparable part of this service, case management services will not be reimbursed separately for periods of time when intensive in-home services are being reimbursed.

B. Therapeutic day treatment for children and adolescents shall be provided in sessions of two or more hours per day, to groups of seriously emotionally disturbed children and adolescents or children at risk of serious emotional disturbance in order to provide therapeutic interventions. Day treatment programs, limited annually to 260 days, provide evaluation, medication education and management, opportunities to learn and use daily living skills and to enhance social and interpersonal skills, and individual, group and family counseling. General program requirements shall be as follows:

1. The provider of therapeutic day treatment for child and adolescent services [~~must~~ shall] be licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services.

2. The minimum staff-to-youth ratio shall ensure that adequate staff is available to meet the needs of the youth identified on the ISP.

3. 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 defined as a minimum of two hours but less than three hours in a given day. Two units of service are defined as a minimum of three but less than five hours in a given day, and three units of service equals five or more hours of service. Transportation time to and from the program site may be included as part of the reimbursable unit. However, transportation time exceeding 25% of the total daily time spent in the service for each individual shall not be billable. These restrictions apply only to transportation to and from the program site. Other program related transportation may be included in the program day as indicated by scheduled activities.

4. When day treatment occurs during the school day, time solely for academic instruction (i.e., when no treatment activity is going on) cannot be included in the billing unit.

C. Day treatment/partial hospitalization services for adults 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 260 days, include the major diagnostic, medical, psychiatric, psychosocial and psychoeducational treatment modalities designed for individuals with serious mental disorders who require coordinated, intensive, comprehensive, and multidisciplinary treatment. General program requirements shall be as follows:

1. The provider of day treatment/partial hospitalization shall be licensed by DMHMRSAS.

2. The program [~~must~~ shall] operate a minimum of two continuous hours in a 24-hour period. 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. Transportation time to and from the program site may be included as part of the reimburseable unit. However, transportation time exceeding 25% of the total daily time spent in the service for each individual shall not be covered. These restrictions shall apply only to transportation to and from the program site. Other program related transportation may be included in the program day as indicated by scheduled program activities.

3. Individuals shall be discharged from this service when they are no longer in an acute psychiatric state or when other less intensive services may achieve stabilization. Admission and services longer than 90 calendar days must be authorized based upon a face-to-face evaluation by a physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, or certified psychiatric nurse.

D. Psychosocial rehabilitation for adults shall be provided in sessions of two or more consecutive hours per day to groups of individuals in a nonresidential setting. These services, limited annually to 312 days, include assessment, medication education, psychoeducation, opportunities to learn and use independent living skills and to enhance social and interpersonal skills, family support, or education within a supportive and normalizing program structure and environment.

1. The provider of psychosocial rehabilitation [~~must~~ shall] be licensed by DMHMRSAS.

2. The program [~~must~~ shall] operate a minimum of two continuous hours in a 24-hour period. A unit of service is defined as a minimum of two but less than four hours on a given day. Two units of service are defined as at least four but less than seven hours in a given day. Three units are defined as seven or more hours in a given day. Transportation time to and from the program site may be included as part of the reimbursement unit. However, transportation time exceeding 25% of the total daily time spent in the service for each individual shall not be covered. These restrictions apply only to transportation to and from the program site. Other program-related transportation may be included in the program day as indicated by scheduled program activities.

3. Time allocated for field trips may be used to calculate time and units of service if the goal is to provide training in an integrated setting, and to increase the client's understanding or ability to access community resources.

E. Crisis intervention shall provide immediate mental health care, available 24 hours a day, seven days per week, to assist individuals who are experiencing acute mental 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, limited annually to 180 hours, shall include assessing the crisis situation, providing short-term counseling designed to stabilize the individual or the family unit, 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, but are not limited to, office visits, home visits, preadmission screenings, telephone contacts, and other client-related activities for the prevention of institutionalization. General program requirements are as follows:

1. The provider of crisis intervention services [~~must~~ shall] be licensed by DMHMRSAS.

2. Client-related activities provided in association with a face-to-face contact shall be reimbursable.

3. An 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 to reflect the short-term counseling goals by the fourth [~~scheduled~~] 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. [When travel

is required to provide out-of-clinic services such time is reimbursable.] Crisis intervention may involve the family or significant others.

§ 3. Mental retardation services.

Day health and rehabilitation services shall be covered and the following definitions shall apply:

A. Day health and rehabilitation services (limited to 500 units per year) shall provide individualized activities, supports, training, supervision, and transportation based on a written plan of care to eligible persons for two or more hours per day scheduled multiple times per week. These services are intended to improve the recipient's condition or to maintain an optimal level of functioning, as well as to ameliorate the recipient's disabilities or deficits by reducing the degree of impairment or dependency. Therapeutic consultation to service providers, family, and friends of the client around implementation of the plan of care may be included as part of the services provided by the day health and rehabilitation program. The provider [~~must~~ shall] be licensed by DMHMRSAS as a Day Support Program. Specific components of day health and rehabilitation services include the following as needed:

1. Self-care and hygiene skills: training in personal appearance and cleanliness, clothing selection/use, personal dental hygiene;

2. Eating skills: training in sitting at table, using utensils, and eating in a reasonable manner; using restaurants;

3. Toilet training skills: training in all steps of toilet process, practice of skills in a variety of public/private environments;

4. Task learning skills: training in eye/hand coordination tasks with varying levels of assistance by supervisors, developing alternative training strategies, providing training and reinforcement in appropriate community settings where such tasks occur;

5. Community resource utilization skills: training in time, telephone, basic computations, money, warning sign recognition, and personal identification such as personal address and telephone number; use of community services, resources and cultural opportunities;

6. Environmental skills: training in punctuality, self-discipline, care of personal belongings, respect for property, remaining on task and adequate attendance; training at actual sites where the skills will be performed;

7. Behavior skills: training in appropriate interaction with supervisors and other trainees, self control of disruptive behaviors, attention to program rules and coping skills, developing/enhancing social skills in relating to the general population, peer groups;

8. Medication management: awareness of importance of prescribed medications, identification of medications, the role of proper dosage and schedules, providing assistance in medication administration, and signs of adverse effects;

9. Travel and related training to and from the training sites and service and support activities;

10. Skills related to the above areas, as appropriate that will enhance or retain the recipient's functioning: training in appropriate manners, language, home care, clothing care, physical awareness and community awareness; opportunities to practice skills in community settings among the general population.

11. Transportation time to and from the program site may be included as part of the reimburseable unit. However, transportation time exceeding 25% of the total daily time spent in the service for each individual shall not be covered. These restrictions apply only to transportation to and from the program site. Other program related transportation may be included in the program day as indicated by scheduled program activities.

B. There shall be two levels of Day Health and Rehabilitation services: Level I and Level II.

1. Level I services shall be provided to individuals who meet the basic program eligibility requirements.

2. Level II services may be provided to individuals who meet the basic program eligibility requirements and for whom one or more of the following indicators are present.

a. The individual requires physical assistance to meet basic personal care needs (toilet training, feeding, medical conditions that require special attention).

b. The individual has extensive disability-related difficulties and requires additional, ongoing support to fully participate in programming and to accomplish individual service goals.

c. The individual requires extensive personal care and/or constant supervision to reduce or eliminate behaviors which preclude full participation in programming. A formal, written behavioral program is required to address behaviors such as, but not limited to, severe depression, self injury, aggression, or self-stimulation.

§ 4. Provider qualification requirements.

To qualify as a provider of services through DMAS for rehabilitative mental health or mental retardation services,

the provider of the services must meet certain criteria. These criteria shall be:

1. The provider [~~must~~ shall] guarantee that clients have access to emergency services on a 24-hour basis;

2. The provider [~~must~~ shall] demonstrate the ability to serve individuals in need of comprehensive services regardless of the individual's ability to pay or eligibility for Medicaid reimbursement;

3. The provider [~~must~~ shall] have the administrative and financial management capacity to meet state and federal requirements;

4. The provider [~~must~~ shall] have the ability to document and maintain individual case records in accordance with state and federal requirements;

5. The services shall be in accordance with the Virginia Comprehensive State Plan for Mental Health, Mental Retardation and Substance Abuse Services; and

6. In addition to those requirements stated above, a provider [~~must~~ shall] meet the following requirements specific to each disability area:

a. Mental health.

(1) Intensive in-home: licensure by DMHMRSAS as an outpatient program.

(2) Therapeutic day treatment for children/adolescents: licensure by DMHMRSAS as a day support program.

(3) Day treatment/partial hospitalization: licensure by DMHMRSAS as a day support program.

(4) Psychosocial rehabilitation: licensure by DMHMRSAS as a day support program.

(5) Crisis intervention: licensure by DMHMRSAS as an Outpatient Program

(6) Case Management: certified by DMHMRSAS

b. Mental retardation.

(1) Day Health and Rehabilitation Services: licensure by DMHMRSAS as a day support program

(2) Case Management: Certified by DMHMRSAS

§ 5. The state assures that the provision of case management services will not restrict an individual's free choice of providers in violation of § 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

§ 6. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

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Title of Regulation: **State Plan for Medical Assistance Relating to Provider Disputes and Date of Acquisition.**
VR 460-03-4.1912. Dispute Resolution for State-Operated Providers.
VR 460-02-4.1920. Methods and Standards for Establishing Payment Rates–Other Types of Care.
VR 460-03-4.1940:1. Nursing Home Payment System (PIRS).

Statutory Authority: § 32.1-325 of the Code of Virginia.

Effective Date: July 1, 1992.

Summary:

The purpose of this action is to (i) adopt a separate procedure for a state-operated provider to contest action taken by DMAS, and (ii) define the "date of acquisition" for revaluation of assets after a change of ownership of a nursing facility.

The sections of the State Plan for Medical Assistance affected by this proposed regulatory action are: Attachment 4.19 A (new Supplement 2 is being added), Attachment 4.19 B, and Attachment 4.19 D, the Supplement (containing the PIRS nursing home payment methodology).

Dispute Resolution for State-Operated Providers: A few state-operated facilities participate in the Medicaid program as contract providers. (Examples include hospitals, home health care agencies, hospital-based nursing facilities, institutions run by the Department of Mental Health, Mental Retardation and Substance Abuse Services, local health department clinics, pharmacies and outpatient dental laboratories, as well as other providers from time to time.) Because a state-operated facility or institution cannot sue or litigate against another agency or arm of the Commonwealth, existing appeal procedures under the Administrative Process Act (which contemplate court review of an agency action) are not appropriate. Therefore, a separate procedure is being established to permit state-operated providers to resolve disagreements.

Date of Acquisition for Nursing Facilities: Federal law provides that, for reimbursement purposes, valuation of capital assets upon a change of ownership of a nursing facility cannot be increased by more than the lesser of two prescribed inflation indices as measured

from the "date of acquisition by the seller" to the date of the change of ownership. The Patient Intensity Rating System nursing home payment system (PIRS) has never defined "date of acquisition." Representatives of the Health Care Financing Administration have defined "the date of acquisition" as the date when legal title passes. As a result of previous discussions between DMAS and providers, DMAS concludes that this term should be defined in PIRS and should also address situations where a nursing facility is constructed by an organization related to the provider (with no formal closing process and no date certain regarding legal title to the physical plant).

VR 460-03-4.1912. Dispute Resolution for State-Operated Providers.

§ 1. Definitions.

"DMAS" means the Department of Medical Assistance Services.

"Division director" means the director of a division of DMAS.

"State-operated provider" means a provider of Medicaid services which is enrolled in the Medicaid program and operated by the Commonwealth of Virginia.

§ 2. Right to request reconsideration.

A. A state-operated provider shall have the right to request a reconsideration for any issue which would be otherwise administratively appealable under the State Plan by a nonstate operated provider. This shall be the sole procedure available to state-operated providers.

B. The appropriate DMAS division must receive the reconsideration request within 30 calendar days after the provider receives its Notice of Amount of Program Reimbursement, notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute.

§ 3. Informal review.

The state-operated provider shall submit to the appropriate DMAS division written information specifying the nature of the dispute and the relief sought. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought, the amount of the adjustment sought, and the reasons for seeking the adjustment. The division director or his designee shall review this information, requesting additional information as necessary. If either party so requests, they may meet to discuss a resolution. Any designee shall then recommend to the division director whether relief is appropriate in accordance with applicable law and regulations.

§ 4. Division director action.

The division director shall consider any recommendation of his designee and shall render a decision.

§ 5. DMAS director review.

A state-operated provider may, within 30 days after receiving the informal review decision of the division director, request that the DMAS director or his designee review the decision of the division director. The DMAS director shall have the authority to take whatever measures he deems appropriate to resolve the dispute.

§ 6. Secretarial review.

If the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, within 30 days after receipt of the decision of the DMAS director, the provider may request the DMAS director to refer the matter to the Secretary of Health and Human Resources and any other Cabinet Secretary as appropriate. Any determination by such Secretary or Secretaries shall be final.

VR 460-02-4.1920. Methods and Standards for Establishing Payment Rates–Other Types of Care.

The policy and the method to be used in establishing payment rates for each type of care or service (other than inpatient hospitalization, skilled nursing and intermediate care facilities) listed in § 1905(a) of the Social Security Act and included in this State Plan for Medical Assistance are described in the following paragraphs:

a. Reimbursement and payment criteria will be established which are designed to enlist participation of a sufficient number of providers of services in the program so that eligible persons can receive the medical care and services included in the Plan at least to the extent these are available to the general population.

b. Participation in the program will be limited to providers of services who accept, as payment in full, the state's payment plus any copayment required under the State Plan.

c. Payment for care or service will not exceed the amounts indicated to be reimbursed in accord with the policy and methods described in this Plan and payments will not be made in excess of the upper limits described in 42 CFR 447.304(a). The state agency has continuing access to data identifying the maximum charges allowed: such data will be made available to the Secretary, HHS, upon request.

d. Payments for services listed below shall be on the basis of reasonable cost following the standards and principles applicable to the Title XVIII Program. 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.

Reasonable costs will be determined from the filing of a uniform cost report by participating providers. The cost reports are due not later than 90 days after the provider's fiscal year end. If a complete cost report is not received within 90 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 which 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.

Item 398 D of the 1987 Appropriation Act (as amended), effective April 8, 1987, eliminated reimbursement of return on equity capital to proprietary providers.

The services that are cost reimbursed are:

(1) Inpatient hospital services to persons over 65 years of age in tuberculosis and mental disease hospitals

(2) Home health care services

(3) Outpatient hospital services excluding laboratory

(4) Rural health clinic services provided by rural health clinics or other federally qualified health centers defined as eligible to receive grants under the Public Health Services Act §§ 329, 330, and 340.

(5) Rehabilitation agencies

(6) Comprehensive outpatient rehabilitation facilities

(7) Rehabilitation hospital outpatient services.

e. Fee-for-service providers. (1) Payment for the following services shall be the lowest of: State agency fee schedule, actual charge (charge to the general public), or Medicare (Title XVIII) allowances:

(a) Physicians' services (Supplement 1 has obstetric/pediatric fees.)

(b) Dentists' services

(c) Mental health services including:

Community mental health services

Services of a licensed clinical psychologist

Mental health services provided by a physician

(d) Podiatry

(e) Nurse-midwife services

(f) Durable medical equipment

(g) Local health services

(h) Laboratory services (Other than inpatient hospital)

(i) Payments to physicians who handle laboratory specimens, but do not perform laboratory analysis (limited to payment for handling)

(j) X-Ray services

(k) Optometry services

(l) Medical supplies and equipment.

(2) Hospice services payments must be no lower than the amounts using the same methodology used under part A of Title XVIII, and adjusted to disregard offsets attributable to Medicare coinsurance amounts.

f. Payment for pharmacy services shall be the lowest of items (1) through (5) (except that items (1) and (2) will not apply when prescriptions are certified as brand necessary by the prescribing physician in accordance with the procedures set forth in 42 CFR 447.331 (c) if the brand cost is greater than the HCFA upper limit of VMAC cost) subject to the conditions, where applicable, set forth in items (6) and (7) below:

(1) The upper limit established by the Health Care Financing Administration (HCFA) for multiple source drugs pursuant to 42 CFR §§ 447.331 and 447.332, as determined by the HCFA 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 Virginia Maximum Allowable Cost (VMAC) established by the agency plus a dispensing fee, if a legend drug, for multiple source drugs listed on the VVF.

(3) The Estimated Acquisition Cost (EAC) which shall be based on the published Average Wholesale Price (AWP) minus a percent discount established by the methodology set out in (a) through (c) below. (Pursuant to OBRA 90 § 4401, from January 1, 1991, through December 31, 1994, no changes in reimbursement limits or dispensing fees shall be made which reduce such limits or fees for covered outpatient drugs).

(a) Percent 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, but no less frequently than triennially.

(4) A mark-up allowance (150%) of the Estimated Acquisition Cost (EAC) for covered nonlegend drugs and oral contraceptives.

(5) The provider's usual and customary charge to the public, as identified by the claim charge.

(6) Payment for pharmacy services will be as described above; however, payments for legend drugs (except oral contraceptives) will include the allowed cost of the drug plus only one dispensing fee per month for each specific drug. Payments will be reduced by the amount of the established copayment per prescription by noninstitutionalized clients with exceptions as provided in federal law and regulation.

(7) The Program recognizes the unit dose delivery system of dispensing drugs only for patients residing in nursing facilities. Reimbursements are based on the allowed payments described above plus the unit dose add on fee and an allowance for the cost of unit dose packaging established by the state agency. The maximum allowed drug cost for specific multiple source drugs will be the lesser of: either the VMAC based on the 60th percentile cost level identified by the state agency or HCFA's upper limits. All other drugs will be reimbursed at drug costs not to exceed the estimated acquisition cost determined by the state agency.

(8) Historical determination of EAC. Determination of EAC was the result of an analysis of FY'89 paid claims data of ingredient cost used to develop a matrix of cost using 0 to 10% reductions from AWP as well as discussions with pharmacy providers. As a result of this analysis, AWP minus 9.0% was determined to represent prices currently paid by providers effective October 1, 1990.

The same methodology used to determine AWP minus 9.0% was utilized to determine a dispensing fee of $4.40 per prescription as of October 1, 1990. A periodic review of dispensing fee using Employment Cost Index - wages and salaries, professional and technical workers will be done with changes made in dispensing fee when appropriate. As of October 1, 1990, the Estimated Acquisition Cost will be AWP minus 9.0% and dispensing fee will be $4.40.

g. All reasonable measures will be taken to ascertain the legal liability of third parties to pay for authorized care and services provided to eligible recipients including those measures specified under 42 USC 1396(a)(25).

h. The single state agency will take whatever measures are necessary to assure appropriate audit of records whenever reimbursement is based on costs of providing care and services, or on a fee-for-service plus cost of materials.

i. Payment for transportation services shall be according to the following table:

TYPE OF SERVICE	PAYMENT METHODOLOGY
Taxi services	Rate set by the single state agency
Wheelchair van	Rate set by the single state agency
Nonemergency ambulance	Rate set by the single state agency
Emergency ambulance	Rate set by the single state agency
Volunteer drivers	Rate set by the single state agency
Air ambulance	Rate set by the single state agency
Mass transit	Rate charged to the public
Transportation agreements	Rate set by the single state agency
Special Emergency transportation	Rate set by the single state agency

j. Payments for Medicare coinsurance and deductibles for noninstitutional services shall not exceed the allowed charges determined by Medicare in accordance with 42 CFR 447.304(b) less the portion paid by Medicare, other third party payors, and recipient copayment requirements of this Plan. See Supplement 2 for this methodology.

k. Payment for eyeglasses shall be the actual cost of the frames and lenses not to exceed limits set by the single state agency, plus a dispensing fee not to exceed limits set by the single state agency.

l. Expanded prenatal care services to include patient education, homemaker, and nutritional services shall be reimbursed at the lowest of: state agency fee schedule, actual charge, or Medicare (Title XVIII) allowances.

m. Targeted case management for high-risk pregnant women and infants up to age 1 shall be reimbursed at the lowest of: state agency fee schedule, actual charge, or Medicare (Title XVIII) allowances.

n. Reimbursement for all other nonenrolled institutional and noninstitutional providers.

(1) All other nonenrolled providers shall be reimbursed the lesser of the charges submitted, the DMAS cost to charge ratio, or the Medicare limits for the services provided.

(2) Outpatient hospitals that are not enrolled as providers with the Department of Medical Assistance Services (DMAS) which submit claims shall be paid based on the DMAS average reimbursable outpatient cost-to-charge ratio, updated annually, for enrolled outpatient hospitals less five percent. The five percent is for the cost of the additional manual processing of the claims. Outpatient hospitals that are nonenrolled shall submit claims on DMAS invoices.

(3) Nonenrolled providers of noninstitutional services shall be paid on the same basis as enrolled in-state providers of noninstitutional services. Nonenrolled providers of physician, dental, podiatry, optometry, and clinical psychology services, etc., shall be reimbursed the lesser of the charges submitted, or the DMAS rates for the services.

(4) All nonenrolled noninstitutional providers shall be reviewed every two years for the number of Medicaid recipients they have served. Those providers who have had no claims submitted in the past twelve months shall be declared inactive.

(5) Nothing in this regulation is intended to preclude DMAS from reimbursing for special services, such as rehabilitation, ventilator, and transplantation, on an exception basis and reimbursing for these services on an individually, negotiated rate basis.

o. Refund of overpayments.

(1) Providers reimbursed on the basis of a fee plus cost of materials.

(a) When DMAS determines an overpayment has been made to a provider, DMAS shall promptly send the first demand letter requesting a lump sum refund. Recovery shall be undertaken even though the provider disputes in whole or in part DMAS's determination of the overpayment.

(b) If the provider cannot refund the total amount of the overpayment within 30 days after receiving the DMAS demand letter, the provider shall promptly request an extended repayment schedule.

DMAS may establish a repayment schedule of up to 12 months to recover all or part of an overpayment or, if a provider demonstrates that repayment within a 12-month period would create severe financial hardship, the Director of the Department of Medical Assistance Services (the "director") may approve a repayment schedule of up to 36 months.

A provider shall have no more than one extended repayment schedule in place at one time. If an audit later uncovers an additional overpayment, the full amount shall be repaid within 30 days unless the provider submits further documentation supporting a modification to the existing extended repayment schedule to include the additional amount.

If, during the time an extended repayment schedule is in effect, the provider withdraws from the Program, the outstanding balance shall become immediately due and payable.

When a repayment schedule is used to recover only part of an overpayment, the remaining amount shall be recovered by the reduction of interim payments to the provider or by lump sum payments.

(c) In the request for an extended repayment schedule, the provider shall document the need for an extended (beyond 30 days) repayment and submit a written proposal scheduling the dates and amounts of repayments. If DMAS approves the schedule, DMAS shall send the provider written notification of the approved repayment schedule, which shall be effective retroactive to the date the provider submitted the proposal.

(d) Once an initial determination of overpayment has been made, DMAS shall undertake full recovery of such overpayment whether the provider disputes, in whole or in part, the initial determination of overpayment. If an appeal follows, interest shall be waived during the period of administrative appeal of an initial determination of overpayment.

Interest charges on the unpaid balance of any overpayment shall accrue pursuant to § 32.1-313 of the Code of Virginia from the date the director's determination becomes final.

The director's determination shall be deemed to be final on (i) the issue date of any notice of overpayment, issued by DMAS, if the provider does not file an appeal, or (ii) the issue date factfinding conference, if the provider does not file an appeal, or (iii) the issue date of any administrative decision signed by the director, regardless of whether a judicial appeal follows. In any event, interest shall be waived if the overpayment is completely liquidated within 30 days of the date of the final determination. In cases in which a determination of overpayment has been judicially reversed, the provider shall be reimbursed that portion of the payment to which it is entitled, plus any applicable interest which the provider paid to DMAS.

(2) Providers reimbursed on the basis of reasonable costs.

(a) When the provider files a cost report indicating that an overpayment has occurred, full refund shall be remitted with the cost report. In cases where DMAS discovers an overpayment during desk review, field audit, or final settlement, DMAS shall promptly send the first demand letter requesting a lump sum refund. Recovery shall be undertaken even though the provider disputes in whole or in part DMAS's determination of the overpayment.

(b) If the provider has been overpaid for a particular fiscal year and has been underpaid for another fiscal year, the underpayment shall be offset against the overpayment. So long as the provider has an overpayment balance, any underpayments discovered by subsequent review or audit shall also be used to reduce the remaining amount of the overpayment.

(c) If the provider cannot refund the total amount of the overpayment (i) at the time it files a cost report indicating that an overpayment has occurred, the provider shall request an extended repayment schedule at the time of filing, or (ii) within 30 days after receiving the DMAS demand letter, the provider shall promptly request an extended repayment schedule.

DMAS may establish a repayment schedule of up to 12 months to recover all or part of an overpayment or, if a provider demonstrates that repayment within a 12-month period would create severe financial hardship, the Director of the Department of Medical Assistance Services (the "director") may approve a repayment schedule of up to 36 months.

A provider shall have no more than one extended repayment schedule in place at one time. If an audit later uncovers an additional overpayment, the full amount shall be repaid within 30 days unless the provider submits further documentation supporting a modification to the existing extended repayment schedule to include the additional amount.

If, during the time an extended repayment schedule is in effect, the provider withdraws from the Program or fails to file a cost report in a timely manner, the outstanding balance shall become immediately due and payable.

When a repayment schedule is used to recover only part of an overpayment, the remaining amount shall be recovered by the reduction of interim payments to the provider or by lump sum payments.

(d) In the request for an extended repayment schedule, the provider shall document the need for an extended (beyond 30 days) repayment and submit a written proposal scheduling the dates and amounts of repayments. If DMAS approves the schedule, DMAS shall send the provider written notification of the approved repayment schedule, which shall be effective retroactive to the date the provider submitted the proposal.

(e) Once an initial determination of overpayment has been made, DMAS shall undertake full recovery of such overpayment whether or not the provider disputes, in whole or in part, the initial determination of overpayment. If an appeal follows, interest shall be waived during the period of administrative appeal of an initial determination of overpayment.

Interest charges on the unpaid balance of any overpayment shall accrue pursuant to § 32.1-313 of the Code of Virginia from the date the director's determination becomes final.

The director's determination shall be deemed to be final on (i) the due date of any cost report filed by the provider indicating that an overpayment has occurred, or (ii) the issue date of any notice of overpayment, issued by DMAS, if the provider does not file an appeal, or (iii) the issue date of any administrative decision issued by DMAS after an informal factfinding conference, if the provider does not file an appeal, or (iv) the issue date of any administrative decision signed by the director, regardless of whether a judicial appeal follows. In any event, interest shall be waived if the overpayment is completely liquidated within 30 days of the date of the final determination. In cases in which a determination of overpayment has been judicially reversed, the provider shall be reimbursed that portion of the payment to which it is entitled, plus any applicable interest which the provider paid to DMAS.

p. Dispute resolution for state-operated providers

(1) Definitions.

(a) "DMAS" means the Department of Medical Assistance Services.

(b) "Division director" means the director of a division of DMAS.

(c) "State-operated provider" means a provider of Medicaid services which is enrolled in the Medicaid program and operated by the Commonwealth of Virginia.

(2) Right to request reconsideration.

(a) A state-operated provider shall have the right to request a reconsideration for any issue which would be otherwise administratively appealable under the State Plan by a nonstate operated provider. This shall be the sole procedure available to state-operated providers.

(b) The appropriate DMAS division must receive the reconsideration request within 30 calendar days after the provider receives its Notice of Amount of Program Reimbursement, notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute.

(3) Informal review. The state-operated provider shall submit to the appropriate DMAS division written information specifying the nature of the dispute and the relief sought. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought, the amount of the adjustment sought, and the reasons for seeking the adjustment. The division director or his designee shall review this information, requesting additional information as necessary. If either party so requests, they may meet to discuss a resolution. Any designee shall then recommend to the division director whether relief is appropriate in accordance with applicable law and regulations.

(4) Division director action. The division director shall consider any recommendation of his designee and shall render a decision.

(5) DMAS director review. A state-operated provider may, within 30 days after receiving the informal review decision of the division director, request that the DMAS director or his designee review the decision of the division director. The DMAS director shall have the authority to take whatever measures he deems appropriate to resolve the dispute.

(6) Secretarial review. If the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, within 30 days after the receipt of the decision of the DMAS director, the provider may request the DMAS director to refer the matter to the Secretary of Health and Human Resources and any other Cabinet Secretary as appropriate. Any determination by such Secretary or Secretaries shall be final.

VR 460-03-4.1940:1. Nursing Home Payment System (PIRS).

PART I.
INTRODUCTION.

§ 1.1. Effective October 1, 1990, the payment methodology for Nursing Facility (NF) reimbursement by the Virginia Department of Medical Assistance Services (DMAS) is set forth in the following document. The formula provides for incentive payments to efficiently operated NFs and contains payment limitations for those NFs operating less efficiently. A cost efficiency incentive encourages cost containment by allowing the provider to retain a percentage of the difference between the prospectively determined operating cost rate and the ceiling.

§ 1.2. Three separate cost components are used: plant cost, operating cost and nurse aide training and competency evaluation program and competency evaluation program (NATCEPs) costs. The rates, which are determined on a facility-by-facility basis, shall be based on annual cost reports filed by each provider.

§ 1.3. In determining the ceiling limitations, there shall be direct patient care medians established for NFs in the Virginia portion of the Washington DC-MD-VA Metropolitan Statistical Area (MSA), the Richmond-Petersburg Metropolitan Statistical Area (MSA), and in the rest of the state. There shall be indirect patient care medians established for NFs in the Virginia portion of the Washington DC-MD-VA MSA, and in the rest of the state. The Washington DC-MD-VA MSA and the Richmond-Petersburg MSA shall include those cities and counties as listed and changed from time to time by the Health Care Financing Administration (HCFA). A NF located in a jurisdiction which HCFA adds to or removes from the Washington DC-MD-VA MSA or the Richmond-Petersburg MSA shall be placed in its new peer group, for purposes of reimbursement, at the beginning of its next fiscal year following the effective date of HCFA's final rule.

§ 1.4. Institutions for mental diseases providing nursing services for individuals age 65 and older shall be exempt from the prospective payment system as defined in §§ 2.6, 2.7, 2.8, 2.19, and 2.25, as are mental retardation facilities. All other sections of this payment system relating to reimbursable cost limitations shall apply. These facilities shall continue to be reimbursed retrospectively on the basis of reasonable costs in accordance with Medicare and Medicaid principles of reimbursement. Reimbursement to Intermediate Care Facilities for the Mentally Retarded (ICF/MR) shall be limited to the highest rate paid to a state ICF/MR institution, approved each July 1 by DMAS.

§ 1.5. Except as specifically modified herein, Medicare principles of reimbursement, as amended from time to time, shall be used to establish the allowable costs in the

rate calculations. Allowable costs must be classified in accordance with the DMAS uniform chart of accounts (see VR 460-03-4.1941, Uniform Expense Classification) and must be identifiable and verified by contemporaneous documentation.

All matters of reimbursement which are part of the DMAS reimbursement system shall supercede Medicare principles of reimbursement. Wherever the DMAS reimbursement system conflicts with Medicare principles of reimbursement, the DMAS reimbursement system shall take precedence. Appendices are a part of the DMAS reimbursement system.

PART II.
RATE DETERMINATION PROCEDURES.

Article 1.
Plant Cost Component.

§ 2.1. Plant cost.

A. Plant cost shall include actual allowable depreciation, interest, rent or lease payments for buildings and equipment as well as property insurance, property taxes and debt financing costs allowable under Medicare principles of reimbursement or as defined herein.

B. To calculate the reimbursement rate, plant cost shall be converted to a per diem amount by dividing it by the greater of actual patient days or the number of patient days computed as 95% of the daily licensed bed complement during the applicable cost reporting period.

C. For NFs of 30 beds or less, to calculate the reimbursement rate, the number of patient days will be computed as not less than 85% of the daily licensed bed complement.

D. Costs related to equipment and portions of a building/facility not available for patient care related activities are nonreimbursable plant costs.

§ 2.2. New nursing facilities and bed additions.

A. 1. Providers shall be required to obtain three competitive bids when (i) constructing a new physical plant or renovating a section of the plant when changing the licensed bed capacity, and (ii) purchasing fixed equipment or major movable equipment related to such projects.

2. All bids must be obtained in an open competitive market manner, and subject to disclosure to DMAS prior to initial rate setting. (Related parties see § 2.10.)

B. Reimbursable costs for building and fixed equipment shall be based upon the 3/4 (25% of the surveyed projects with costs above the median, 75% with costs below the median) square foot costs for NFs published annually in the R.S. Means Building Construction Cost Data as adjusted by the appropriate R.S. Means Square Foot Costs "Location Factor" for Virginia for the locality in which the NF is located. Where the specific location is not listed in the R.S. Means Square Foot Costs "Location Factor" for Virginia, the facility's zip code shall be used to determine the appropriate locality factor from the U.S. Postal Services National Five Digit Zip Code for Virginia and the R.S. Means Square Foot Costs "Location Factors." The provider shall have the option of selecting the construction cost limit which is effective on the date the Certificate of Public Need (COPN) is issued or the date the NF is licensed. Total cost shall be calculated by multiplying the above 3/4 square foot cost by 385 square feet (the average per bed square footage). Total costs for building additions shall be calculated by multiplying the square footage of the project by the applicable components of the construction cost in the R.S. Means Square Foot Costs, not to exceed the total per bed cost for a new NF. Reasonable limits for renovations shall be determined by the appropriate costs in the R.S. Means Repair and Remodeling Cost Data, not to exceed the total R.S. Means Building Construction Cost Data 3/4 square foot costs for nursing homes.

C. New NFs and bed additions to existing NFs must have prior approval under the state's Certificate of Public Need Law and Licensure regulations in order to receive Medicaid reimbursement.

D. However in no case shall allowable reimbursed costs exceed 110% of the amounts approved in the original COPN, or 100% of the amounts approved in the original COPN as modified by any "significant change" COPN, where a provider has satisfied the requirements of the State Department of Health with respect to obtaining prior written approval for a "significant change" to a COPN which has previously been issued.

§ 2.3. Major capital expenditures.

A. Major capital expenditures include, but are not limited to, major renovations (without bed increase), additions, modernization, other renovations, upgrading to new standards, and equipment purchases. Major capital expenditures shall be any capital expenditures costing $100,000 or more each, in aggregate for like items, or in aggregate for a particular project. These include purchases of similar type equipment or like items within a one calendar year period (not necessarily the provider's reporting period).

B. Providers (including related organizations as defined in § 2.10) shall be required to obtain three competitive bids and if applicable, a Certificate of Public Need before initiating any major capital expenditures. All bids must be obtained in an open competitive manner, and subject to disclosure to the DMAS prior to initial rate setting. (Related parties see § 2.10.)

C. Useful life shall be determined by the American

Hospital Association's Estimated Useful Lives of Depreciable Hospital Assets (AHA). If the item is not included in the AHA guidelines, reasonableness shall be applied to determine useful life.

D. Major capital additions, modernization, renovations, and costs associated with upgrading the NF to new standards shall be subject to cost limitations based upon the applicable components of the construction cost limits determined in accordance with § 2.2 B.

§ 2.4. Financing.

A. The DMAS shall continue its policy to disallow cost increases due to the refinancing of a mortgage debt, except when required by the mortgage holder to finance expansions or renovations. Refinancing shall also be permitted in cases where refinancing would produce a lower interest rate and result in a cost savings. The total net aggregate allowable costs incurred for all cost reporting periods related to the refinancing cannot exceed the total net aggregate costs that would have been allowable had the refinancing not occurred.

1. Refinancing incentive. Effective July 1, 1991, for mortgages refinanced on or after that date, the DMAS will pay a refinancing incentive to encourage nursing facilities to refinance fixed-rate, fixed-term mortgage debt when such arrangements would benefit both the Commonwealth and the providers. The refinancing incentive payments will be made for the 10-year period following an allowable refinancing action, or through the end of the refinancing period should the loan be less than 10 years, subject to a savings being realized by application of the refinancing calculation for each of these years. The refinancing incentive payment shall be computed on the net savings from such refinancing applicable to each provider cost reporting period. Interest expense and amortization of loan costs on mortgage debt applicable to the cost report period for mortgage debt which is refinanced shall be compared to the interest expense and amortization of loan costs on the new mortgage debt for the cost reporting period.

2. Calculation of refinancing incentive. The incentive shall be computed by calculating two index numbers, the old debt financing index and the new debt financing index. The old debt financing index shall be computed by multiplying the term (months) which would have been remaining on the old debt at the end of the provider's cost report period by the interest rate for the old debt. The new debt index shall be computed by multiplying the remaining term (months) of the new debt at the end of the cost reporting period by the new interest rate. The new debt index shall be divided by the old debt index to achieve a savings ratio for the period. The savings ratio shall be subtracted from a factor of 1 to determine the refinancing incentive factor.

3. Calculation of net savings. The gross savings for the period shall be computed by subtracting the allowable new debt interest for the period from the allowable old debt interest for the period. The net savings for the period shall be computed by subtracting allowable new loan costs for the period from allowable gross savings applicable to the period. Any remaining unamortized old loan costs may be recovered in full to the extent of net savings produced for the period.

4. Calculation of incentive amount. The net savings for the period, after deduction of any unamortized old loan and debt cancellation costs, shall be multiplied by the refinancing incentive factor to determine the refinancing incentive amount. The result shall be the incentive payment for the cost reporting period, which shall be included in the cost report settlement, subject to per diem computations under § 2.1 B, 2.1 C, and 2.14 A.

5. Where a savings is produced by a provider refinancing his old mortgage for a longer time period, the DMAS shall calculate the refinancing incentive and payment in accordance with §§ 2.4 A 1 through 2.4 A 4 for the incentive period. Should the calculation produce both positive and negative incentives, the provider's total incentive payments shall not exceed any net positive amount for the entire incentive period. Where a savings is produced by refinancing with either a principal balloon payment at the end of the refinancing period, or a variable interest rate, no incentive payment will be made, since the true savings to the Commonwealth cannot be accurately computed.

6. All refinancings must be supported by adequate and verifiable documentation and allowable under DMAS regulations to receive the refinancing savings incentive.

B. Interest rate upper limit.

Financing for all NFs and expansions which require a COPN and all renovations and purchases shall be subject to the following limitations:

1. Interest expenses for debt financing which is exempt from federal income taxes shall be limited to:

The average weekly rates for Baa municipal rated bonds as published in Cragie Incorporated Municipal Finance Newsletter as published weekly (Representative reoffering from general obligation bonds), plus one percentage point (100 basis points), during the week in which commitment for construction financing or closing for permanent financing takes place.

2. a. Effective on and after July 1, 1990, the interest rate upper limit for debt financing by NFs that are subject to prospective reimbursement shall be the average of the rate for 10-year and 30-year U.S.

Treasury Constant Maturities, as published in the weekly Federal Reserve Statistical Release (H.15), plus two percentage points (200 basis points).

This limit (i) shall apply only to debt financing which is not exempt from federal income tax, and (ii) shall not be available to NF's which are eligible for such tax exempt financing unless and until a NF has demonstrated to the DMAS that the NF failed, in a good faith effort, to obtain any available debt financing which is exempt from federal income tax. For construction financing, the limit shall be determined as of the date on which commitment takes place. For permanent financing, the limit shall be determined as of the date of closing. The limit shall apply to allowable interest expenses during the term of the financing.

b. The new interest rate upper limit shall also apply, effective July 1, 1990, to construction financing committed to or permanent financing closed after December 31, 1986, but before July 1, 1990, which is not exempt from federal income tax. The limit shall be determined as of July 1, 1990, and shall apply to allowable interest expenses for the term of the financing remaining on or after July 1, 1990.

3. Variable interest rate upper limit.

a. The limitation set forth in §§ 2.4 B 1 and 2.4 B 2 shall be applied to debt financing which bears a variable interest rate as follows. The interest rate upper limit shall be determined on the date on which commitment for construction financing or closing for permanent financing takes place, and shall apply to allowable interest expenses during the term of such financing as if a fixed interest rate for the financing period had been obtained. A "fixed rate loan amortization schedule" shall be created for the loan period, using the interest rate cap in effect on the date of commitment for construction financing or date of closing for permanent financing.

b. If the interest rate for any cost reporting period is below the limit determined in subdivision 3 a above, no adjustment will be made to the providers interest expense for that period, and a "carryover credit" to the extent of the amount allowable under the "fixed rate loan amortization schedule" will be created, but not paid. If the interest rate in a future cost reporting period is above the limit determined in subdivision 3 a above, the provider will be paid this "carryover credit" from prior period(s), not to exceed the cumulative carryover credit or his actual cost, whichever is less.

c. The provider shall be responsible for preparing a verifiable and auditable schedule to support cumulative computations of interest claimed under the "carryover credit," and shall submit such a schedule with each cost report.

4. The limitation set forth in § 2.4 B 1, 2, and 3 shall be applicable to financing for land, buildings, fixed equipment, major movable equipment, working capital for construction and permanent financing.

5. Where bond issues are used as a source of financing, the date of sale shall be considered as the date of closing.

6. The aggregate of the following costs shall be limited to 5.0% of the total allowable project costs:

a. Examination Fees

b. Guarantee Fees

c. Financing Expenses (service fees, placement fees, feasibility studies, etc.)

d. Underwriters Discounts

e. Loan Points

7. The aggregate of the following financing costs shall be limited to 2.0% of the total allowable project costs:

a. Legal Fees

b. Cost Certification Fees

c. Title and Recording Costs

d. Printing and Engraving Costs

e. Rating Agency Fees

C. DMAS shall allow costs associated with mortgage life insurance premiums in accordance with § 2130 of the HCFA-Pub. 15, Provider Reimbursement Manual (PRM-15).

D. Interest expense on a debt service reserve fund is an allowable expense if required by the terms of the financing agreement. However, interest income resulting from such fund shall be used by DMAS to offset interest expense.

§ 2.5. Purchases of nursing facilities (NF).

A. In the event of a sale of a NF, the purchaser must have a current license and certification to receive DMAS reimbursement as a provider.

B. The following reimbursement principles shall apply to the purchase of a NF:

1. The allowable cost of a bona fide sale of a facility (whether or not the parties to the sale were, are, or will be providers of Medicaid services) shall be the lowest of the sales price, the replacement cost value

determined by independent appraisal, or the limitations of Part XVI - Revaluation of Assets. Revaluation of assets shall be permitted only when a bona fide sale of assets occurs.

2. Notwithstanding the provisions of § 2.10, where there is a sale between related parties (whether or not they were, are or will be providers of Medicaid services), the buyer's allowable cost basis for the nursing facility shall be the seller's allowable depreciated historical cost (net book value), as determined for Medicaid reimbursement.

3. For purposes of Medicaid reimbursement, a "bona fide" sale shall mean a transfer of title and possession for consideration between parties which are not related. Parties shall be deemed to be "related" if they are related by reasons of common ownership or control. If the parties are members of an immediate family, the sale shall be presumed to be between related parties if the ownership or control by immediate family members, when aggregated together, meets the definitions of "common ownership" or "control." See § 2.10 C for definitions of "common ownership," "control," "immediate family," and "significant ownership or control."

4. The useful life of the fixed assets of the facility shall be determined by AHA guidelines.

5. The buyer's basis in the purchased assets shall be reduced by the value of the depreciation recapture due the state by the provider-seller, until arrangements for repayment have been agreed upon by DMAS.

6. In the event the NF is owned by the seller for less than five years, the reimbursable cost basis of the purchased NF to the buyer, shall be the seller's allowable historical cost as determined by DMAS.

C. An appraisal expert shall be defined as an individual or a firm that is experienced and specializes in multi-purpose appraisals of plant assets involving the establishing or reconstructing of the historical cost of such assets. Such an appraisal expert employs a specially trained and supervised staff with a complete range of appraisal and cost construction techniques; is experienced in appraisals of plant assets used by providers, and demonstrates a knowledge and understanding of the regulations involving applicable reimbursement principles, particularly those pertinent to depreciation; and is unrelated to either the buyer or seller.

D. At a minimum, appraisals must include a breakdown by cost category as follows:

1. Building; fixed equipment; movable equipment; land; land improvements.

2. The estimated useful life computed in accordance with AHA guidelines of the three categories, building, fixed equipment, and movable equipment must be included in the appraisal. This information shall be utilized to compute depreciation schedules.

E. Depreciation recapture.

1. The provider-seller of the facility shall make a retrospective settlement with DMAS in instances where a gain was made on disposition. The department shall recapture the depreciation paid to the provider by Medicaid for the period of participation in the Program to the extent there is gain realized on the sale of the depreciable assets. A final cost report and refund of depreciation expense, where applicable, shall be due within 30 days from the transfer of title (as defined below).

2. No depreciation adjustment shall be made in the event of a loss or abandonment.

F. Reimbursable depreciation.

1. For the purpose of this section, "sale or transfer" shall mean any agreement between the transferor and the transferee by which the former, in consideration of the payment or promise of payment of a certain price in money, transfers to the latter the title and possession of the property.

2. Upon the sale or transfer of the real and tangible personal property comprising a licensed nursing facility certified to provide services to DMAS, the transferor or other person liable therein shall reimburse to the Commonwealth the amount of depreciation previously allowed as a reasonable cost of providing such services and subject to recapture under the provisions of the State Plan for Medical Assistance. The amount of reimbursable depreciation shall be paid to the Commonwealth within 30 days of the sale or transfer of the real property unless an alternative form of repayment, the term of which shall not exceed one year, is approved by the director.

3. Prior to the transfer, the transferor shall file a written request by certified or registered mail to the director for a letter of verification that he either does not owe the Commonwealth any amount for reimbursable depreciation or that he has repaid any amount owed the Commonwealth for reimbursable depreciation or that an alternative form of repayment has been approved by the director. The request for a letter of verification shall state:

a. That a sale or transfer is about to be made;

b. The location and general description of the property to be sold or transferred;

c. The names and addresses of the transferee and

transferor and all such business names and addresses of the transferor for the last three years; and

d. Whether or not there is a debt owing to the Commonwealth for the amount of depreciation charges previously allowed and reimbursed as a reasonable cost to the transferor under the Virginia Medical Assistance Program.

4. Within 90 days after receipt of the request, the director shall determine whether or not there is an amount due to the Commonwealth by the nursing facility by reason of depreciation charges previously allowed and reimbursed as a reasonable cost under DMAS and shall notify the transferor of such sum, if any.

5. The transferor shall provide a copy of this section and a copy of his request for a letter of verification to the prospective transferee via certified mail at least 30 days prior to the transfer. However, whether or not the transferor provides a copy of this section and his request for verification to the prospective transferee as required herein, the transferee shall be deemed to be notified of the requirements of this law.

6. After the transferor has made arrangements satisfactory to the director to repay the amount due or if there is no amount due, the director shall issue a letter of verification to the transferor in recordable form stating that the transferor has complied with the provisions of this section and setting forth the term of any alternative repayment agreement. The failure of the transferor to reimburse to the Commonwealth the amount of depreciation previously allowed as a reasonable cost of providing service to DMAS in a timely manner renders the transfer of the nursing facility ineffective as to the Commonwealth.

7. Upon a finding by the director that such sale or transfer is ineffective as to the Commonwealth, DMAS may collect any sum owing by any means available by law, including devising a schedule for reducing the Medicaid reimbursement to the transferee up to the amount owed the Commonwealth for reimbursable depreciation by the transferor or other person liable therein. Medicaid reimbursement to the transferee shall continue to be so reduced until repayment is made in full or the terms of the repayment are agreed to by the transferor or person liable therein.

8. In the event the transferor or other person liable therein defaults on any such repayment agreement the reductions of Medicaid reimbursement to the transferee may resume.

An action brought or initiated to reduce the transferee's Medicaid reimbursement or an action for attachment or levy shall not be brought or initiated more than six months after the date on which the sale or transfer has taken place unless the sale or transfer has been concealed or a letter of verification has not been obtained by the transferor or the transferor defaults on a repayment agreement approved by the director.

Article 2.
Operating Cost Component.

§ 2.6. Operating cost.

A. Operating cost shall be the total allowable inpatient cost less plant cost and NATCEPs costs. See Part VII for rate determination procedures for NATCEPs costs. To calculate the reimbursement rate, operating cost shall be converted to a per diem amount by dividing it by the greater of actual patient days, or the number of patient days computed as 95% of the daily licensed bed complement during the applicable cost reporting period.

B. For NFs of 30 beds or less, to calculate the reimbursement rate the number of patient days will continue to be computed as not less than 85% of the daily licensed bed complement.

§ 2.7. Nursing facility reimbursement formula.

A. Effective on and after October 1, 1990, all NFs subject to the prospective payment system shall be reimbursed under a revised formula entitled "The Patient Intensity Rating System (PIRS)." PIRS is a patient based methodology which links NF's per diem rates to the intensity of services required by a NF's patient mix. Three classes were developed which group patients together based on similar functional characteristics and service needs.

1. Any NF receiving Medicaid payments on or after October 1, 1990, shall satisfy all the requirements of § 1919(b) through (d) of the Social Security Act as they relate to provision of services, residents' rights and administration and other matters.

2. In accordance with § 1.3, direct patient care operating cost peer groups shall be established for the Virginia portion of the Washington DC-MD-VA MSA, the Richmond-Petersburg MSA and the rest of the state. Direct patient care operating costs shall be as defined in VR 460-03-1491. Indirect patient care operating cost peer groups shall be established for the Virginia portion of the Washington DC-MD-VA MSA and for the rest of the state. Indirect patient care operating costs shall include all other operating costs, not defined in VR 460-03-4.1941 as direct patient care operating costs and NATCEPs costs.

3. Each NF's Service Intensity Index (SII) shall be calculated for each semiannual period of a NF's fiscal year based upon data reported by that NF and entered into DMAS' Long Term Care Information System (LTCIS). Data will be reported on the

multidimensional assessment form prescribed by DMAS (now DMAS-95) at the time of admission and then twice a year for every Medicaid recipient in a NF. The NF's SII, derived from the assessment data, will be normalized by dividing it by the average for all NF's in the state.

See VR 460-03-4.1944 for the PIRS class structure, the relative resource cost assigned to each class, the method of computing each NF's facility score and the methodology of computing the NF's semiannual SIIs.

4. The normalized SII shall be used to calculate the initial direct patient care operating cost peer group medians. It shall also be used to calculate the direct patient care operating cost prospective ceilings and direct patient care operating cost prospective rates for each semiannual period of a NF's subsequent fiscal years.

a. The normalized SII, as determined during the quarter ended September 30, 1990, shall be used to calculate the initial direct patient care operating cost peer group medians.

b. A NF's direct patient care operating cost prospective ceiling shall be the product of the NF's peer group direct patient care ceiling and the NF's normalized SII for the previous semiannual period. A NF's direct patient care operating cost prospective ceiling will be calculated semiannually.

c. An SSI rate adjustment, if any, shall be applied to a NF's prospective direct patient care operating cost base rate for each semiannual period of a NF's fiscal year. The SII determined in the second semiannual period of the previous fiscal year shall be divided by the average of the previous fiscal year's SIIs to determine the SII rate adjustment, if any, to the first semiannual period of the subsequent fiscal year's prospective direct patient care operating cost base rate. The SII determined in the first semiannual period of the subsequent fiscal year shall be divided by the average of the previous fiscal year's SIIs to determine the SII rate adjustment, if any, to the second semiannual period of the subsequent fiscal year's prospective direct patient care operating cost base rate.

d. See VR 460-03-4.1944 for an illustration of how the SII is used to adjust direct patient care operating ceilings and the semiannual rate adjustments to the prospective direct patient care operating cost base rate.

5. An adjustment factor shall be applied to both the direct patient care and indirect patient care peer group medians to determine the appropriate initial peer group ceilings.

a. The DMAS shall calculate the estimated gross NF reimbursement required for the forecasted number of NF bed days during fiscal year 1991 under the prospective payment system in effect through September 30, 1990, as modified to incorporate the estimated additional NF reimbursement mandated by the provisions of § 1902(a)(13)(A) of the Social Security Act as amended by § 4211(b)(1) of the Omnibus Budget Reconciliation Act of 1987.

b. The DMAS shall calculate the estimated gross NF reimbursement required for the forecasted number of NF bed days during FY 1991 under the PIRS prospective payment system.

c. The DMAS shall determine the differential between a and b above and shall adjust the peer group medians within the PIRS as appropriate to reduce the differential to zero.

d. The adjusted PIRS peer group medians shall become the initial peer group ceilings.

B. The allowance for inflation shall be based on the percentage of change in the moving average of the Skilled Nursing Facility Market basket of Routine Service Costs, as developed by Data Resources, Incorporated, adjusted for Virginia, determined in the quarter in which the NF's most recent fiscal year ended. NFs shall have their prospective operating cost ceilings and prospective operating cost rates established in accordance with the following methodology:

1. The initial peer group ceilings established under § 2.7 A shall be the final peer group ceilings for a NF's first full or partial fiscal year under PIRS and shall be considered as the initial "interim ceilings" for calculating the subsequent fiscal year's peer group ceilings. Peer group ceilings for subsequent fiscal years shall be calculated by adjusting the initial "interim" ceilings by a "percentage factor" which shall eliminate any allowances for inflation after September 30, 1990, calculated in both §§ 2.7 A 5 a and 2.7 A 5 c. The adjusted initial "interim" ceilings shall be considered as the final "interim ceiling." Peer group ceilings for subsequent fiscal years shall be calculated by adjusting the final "interim" ceiling, as determined above, by 100% of historical inflation from October 1, 1990, to the beginning of the NFs next fiscal year to obtain new "interim" ceilings, and 50% of the forecasted inflation to the end of the NFs next fiscal year.

2. A NF's average allowable operating cost rates, as determined from its most recent fiscal year's cost report, shall be adjusted by 50% of historical inflation and 50% of the forecasted inflation to calculate its prospective operating cost base rates.

C. The PIRS method shall still require comparison of the prospective operating cost rates to the prospective operating ceilings. The provider shall be reimbursed the

lower of the prospective operating cost rates or prospective operating ceilings.

D. Nonoperating costs.

1. Allowable plant costs shall be reimbursed in accordance with Part II, Article 1. Plant costs shall not include the component of cost related to making or producing a supply or service.

2. NATCEPs cost shall be reimbursed in accordance with Part VII.

E. The prospective rate for each NF shall be based upon operating cost and plant cost components or charges, whichever is lower, plus NATCEPs costs. The disallowance of nonreimbursable operating costs in any current fiscal year shall be reflected in a subsequent year's prospective rate determination. Disallowances of nonreimbursable plant costs and NATCEPs costs shall be reflected in the year in which the nonreimbursable costs are included.

F. For those NFs whose operating cost rates are below the ceilings, an incentive plan shall be established whereby a NF shall be paid, on a sliding scale, up to 25% of the difference between its allowable operating cost rates and the peer group ceilings under the PIRS.

1. The table below presents four incentive examples under the PIRS:

Peer Group Ceilings	Allowable Cost Per Day		Difference % of Ceiling	Sliding Scale	Scale % Difference
$30.00	$27.00	$3.00	10%	$ .30	10%
30.00	22.50	7.50	25%	1.88	25%
30.00	20.00	10.00	33%	2.50	25%
30.00	30.00	0		0	

2. Separate efficiency incentives shall be calculated for both the direct and indirect patient care operating ceilings and costs.

G. Quality of care requirement.

A cost efficiency incentive shall not be paid to a NF for the prorated period of time that it is not in conformance with substantive, nonwaived life, safety, or quality of care standards.

H. Sale of facility.

In the event of the sale of a NF, the prospective base operating cost rates for the new owner's first fiscal period shall be the seller's prospective base operating cost rates before the sale.

I. Public notice.

To comply with the requirements of § 1902(a)(28)(c) of the Social Security Act, DMAS shall make available to the public the data and methodology used in establishing Medicaid payment rates for nursing facilities. Copies may be obtained by request under the existing procedures of the Virginia Freedom of Information Act.

§ 2.8. Phase-in period.

A. To assist NFs in converting to the PIRS methodology, a phase-in period shall be provided until June 30, 1992.

B. From October 1, 1990, through June 30, 1991, a NF's prospective operating cost rate shall be a blended rate calculated at 33% of the PIRS operating cost rates determined by § 2.7 above and 67% of the "current" operating rate determined by subsection D below.

C. From July 1, 1991, through June 30, 1992, a NF's prospective operating cost rate shall be a blended rate calculated at 67% of the PIRS operating cost rates determined by § 2.7 above and 33% of the "current" operating rate determined by subsection D below.

D. The following methodology shall be applied to calculate a NF's "current" operating rate:

1. Each NF shall receive as its base "current" operating rate, the weighted average prospective operating cost per diems and efficiency incentive per diems if applicable, calculated by DMAS to be effective September 30, 1990.

2. The base "current" operating rate established above shall be the "current" operating rate for the NF's first partial fiscal year under PIRS. The base "current" operating rate shall be adjusted by appropriate allowance for historical inflation and 50% of the forecasted inflation based on the methodology contained in § 2.7 B at the beginning of each of the NF's fiscal years which starts during the phase-in period, October 1, 1990, through June 30, 1992, to determine the NF's prospective "current" operating rate. See VR 460-03-4.1944 for example calculations.

§ 2.8.1. Nursing facility rate change.

For the period beginning July 1, 1991, and ending June 30, 1992, the per diem operating rate for each NF shall be adjusted. This shall be accomplished by applying a uniform adjustment factor to the rate of each NF.

Article 3.
Allowable Cost Identification.

§ 2.9. Allowable costs.

Costs which are included in rate determination procedures and final settlement shall be only those allowable, reasonable costs which are acceptable under the Medicare principles of reimbursement, except as specifically modified in the Plan and as may be subject to individual or ceiling cost limitations and which are classified in accordance with the DMAS uniform chart of

accounts (see VR 460-03-4.1941, Uniform Expense Classification).

A. Certification.

The cost of meeting all certification standards for NF requirements as required by the appropriate state agencies, by state laws, or by federal legislation or regulations.

B. Operating costs.

1. Direct patient care operating costs shall be defined in VR 460-03-4.1941.

2. Allowable direct patient care operating costs shall exclude (i) personal physician fees, and (ii) pharmacy services and prescribed legend and nonlegend drugs provided by nursing facilities which operate licensed in-house pharmacies. These services shall be billed directly to DMAS through separate provider agreements and DMAS shall pay directly in accordance with subsections e and f of Attachment 4.19 B of the State Plan for Medical Assistance (VR 460-02-4.1920).

3. Indirect patient care operating costs include all other operating costs, not identified as direct patient care operating costs and NATCEPs costs in VR 460-03-4.1941, which are allowable under the Medicare principles of reimbursement, except as specifically modified herein and as may be subject to individual cost or ceiling limitations.

C. Allowances/goodwill.

Bad debts, goodwill, charity, courtesy, and all other contractual allowances shall not be recognized as an allowable cost.

§ 2.10. Purchases/related organizations.

A. Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control shall be included in the allowable cost of the provider at the cost to the related organization, provided that such costs do not exceed the price of comparable services, facilities or supplies. Purchases of existing NFs by related parties shall be governed by the provisions of § 2.5 B 2.

Allowable cost applicable to management services furnished to the provider by organizations related to the provider by common ownership or control shall be lesser of the cost to the related organization or the per patient day ceiling limitation established for management services cost. (See VR 460-03-4.1943, Cost Reimbursement Limitations.)

B. Related to the provider shall mean that the provider is related by reasons of common ownership or control by the organization furnishing the services, facilities, or supplies.

C. Common ownership exists when an individual or individuals or entity or entities possess significant ownership or equity in the parties to the transaction. Control exists where an individual or individuals or entity or entities have the power, directly or indirectly, significantly to influence or direct the actions or policies of the parties to the transaction. Significant ownership or control shall be deemed to exist where an individual is a "person with an ownership or control interest" within the meaning of 42 CFR 455.101. If the parties to the transaction are members of an immediate family, as defined below, the transaction shall be presumed to be between related parties if the ownership or control by immediate family members, when aggregated together, meets the definitions of "common ownership" or "control," as set forth above. Immediate family shall be defined to include, but not be limited to, the following: (i) husband and wife, (ii) natural parent, child and sibling, (iii) adopted child and adoptive parent, (iv) step-parent, step-child, step-sister, and step-brother, (v) father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law and daughter-in-law, and (vi) grandparent and grandchild.

D. Exception to the related organization principle.

1. Effective with cost reports having fiscal years beginning on or after July 1, 1986, an exception to the related organization principle shall be allowed. Under this exception, charges by a related organization to a provider for goods or services shall be allowable cost to the provider if all four of the conditions set out below are met.

2. The exception applies if the provider demonstrates by convincing evidence to the satisfaction of DMAS that the following criteria have been met:

a. The supplying organization is a bona fide separate organization. This means that the supplier is a separate sole proprietorship, partnership, joint venture, association or corporation and not merely an operating division of the provider organization.

b. A substantial part of the supplying organization's business activity of the type carried on with the provider is transacted with other organizations not related to the provider and the supplier by common ownership or control and there is an open, competitive market for the type of goods or services furnished by the organization. In determining whether the activities are of similar type, it is important to also consider the scope of the activity.

For example, a full service management contract would not be considered the same type of business activity as a minor data processing contract. The requirement that there be an open, competitive market is merely intended to assure that the item

supplied has a readily discernible price that is established through arms-length bargaining by well informed buyers and sellers.

c. The goods or services shall be those which commonly are obtained by institutions such as the provider from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by such institutions. This requirement means that institutions such as the provider typically obtain the good or services from outside sources rather than producing the item internally.

d. The charge to the provider is in line with the charge for such services, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such goods or services. The phrase "open market" takes the same meaning as "open, competitive market" in subdivision b above.

3. Where all of the conditions of this exception are met, the charges by the supplier to the provider for such goods or services shall be allowable as costs.

4. This exception does not apply to the purchase, lease or construction of assets such as property, buildings, fixed equipment or major movable equipment. The terms "goods and services" may not be interpreted or construed to mean capital costs associated with such purchases, leases, or construction.

E. Three competitive bids shall not be required for the building and fixed equipment components of a construction project outlined in § 2.2. Reimbursement shall be in accordance with § 2.10 A with the limitations stated in § 2.2 B.

§ 2.11. Administrator/owner compensation.

A. Administrators' compensation, whether administrators are owners or non-owners, shall be based on a schedule adopted by DMAS and varied according to facility bed size. The compensation schedule shall be adjusted annually to reflect cost-of-living increases and shall be published and distributed to providers annually. The administrator's compensation schedule covers only the position of administrator and assistants and does not include the compensation of owners employed in capacities other than the NF administrator (see VR 460-03-4.1943, Cost Reimbursement Limitations).

B. Administrator compensation shall mean remuneration paid regardless of the form in which it is paid. This includes, but shall not be limited to, salaries, professional fees, insurance premiums (if the benefits accrue to the employer/owner or his beneficiary) director fees, personal use of automobiles, consultant fees, management fees, travel allowances, relocation expenses in excess of IRS guidelines, meal allowances, bonuses, pension plan costs, and deferred compensation plans. Management fees, consulting fees, and other services performed by owners shall be included in the total compensation if they are performing administrative duties regardless of how such services may be classified by the provider.

C. Compensation for all administrators (owner and nonowner) shall be based upon a 40 hour week to determine reasonableness of compensation.

D. Owner/administrator employment documentation.

1. Owners who perform services for a NF as an administrator and also perform additional duties must maintain adequate documentation to show that the additional duties were performed beyond the normal 40 hour week as an administrator. The additional duties must be necessary for the operation of the NF and related to patient care.

2. Services provided by owners, whether in employee capacity, through management contracts, or through home office relationships shall be compared to the cost and services provided in arms-length transactions.

3. Compensation for such services shall be adjusted where such compensation exceeds that paid in such arms-length transaction or where there is a duplication of duties normally rendered by an administrator. No reimbursement shall be allowed for compensation where owner services cannot be documented and audited.

§ 2.12. Depreciation.

The allowance for depreciation shall be restricted to the straight line method with a useful life in compliance with AHA guidelines. If the item is not included in the AHA guidelines, reasonableness shall be applied to determine useful life.

§ 2.13. Rent/Leases.

Rent or lease expenses shall be limited by the provisions of VR 460-03-4.1942, Leasing of Facilities.

§ 2.14. Provider payments.

A. Limitations.

1. Payments to providers, shall not exceed charges for covered services except for (i) public providers furnishing services free of charge or at a nominal charge (ii) nonpublic provider whose charges are 60% or less of the allowable reimbursement represented by the charges and that demonstrates its charges are less than allowable reimbursement because its customary practice is to charge patients based on their ability to pay. Nominal charge shall be defined as total charges that are 60% or less of the allowable reimbursement of services represented by these charges. Providers

qualifying in this section shall receive allowable reimbursement as determined in this Plan.

2. Allowable reimbursement in excess of charges may be carried forward for payment in the two succeeding cost reporting periods. A new provider may carry forward unreimbursed allowable reimbursement in the five succeeding cost reporting periods.

3. Providers may be reimbursed the carry forward to a succeeding cost reporting period (i) if total charges for the services provided in that subsequent period exceed the total allowable reimbursement in that period (ii) to the extent that the accumulation of the carry forward and the allowable reimbursement in that subsequent period do not exceed the providers' direct and indirect care operating ceilings plus allowable plant cost.

B. Payment for service shall be based upon the rate in effect when the service was rendered.

C. An interim settlement shall be made by DMAS within 90 days after receipt and review of the cost report. The word "review," for purposes of interim settlement, shall include verification that all financial and other data specifically requested by DMAS is submitted with the cost report. Review shall also mean examination of the cost report and other required submission for obvious errors, inconsistency, inclusion of past disallowed costs, unresolved prior year cost adjustments and a complete signed cost report that conforms to the current DMAS requirements herein.

However, an interim settlement shall not be made when one of the following conditions exists.

1. Cost report filed by a terminated provider;

2. Insolvency of the provider at the time the cost report is submitted;

3. Lack of a valid provider agreement and decertification;

4. Moneys owed to DMAS;

5. Errors or inconsistencies in the cost report; or

6. Incomplete/nonacceptable cost report.

§ 2.15. Legal fees/accounting.

A. Costs claimed for legal/accounting fees shall be limited to reasonable and customary fees for specific services rendered. Such costs must be related to patient care as defined by Medicare principles of reimbursement and subject to applicable regulations herein. Documentation for legal costs must be available at the time of audit.

B. Retainer fees shall be considered an allowable cost up to the limits established in VR 460-03-4.1943, Cost Reimbursement Limitations.

C. As mandated by the Omnibus Budget Reconciliation Act of 1990, effective November 5, 1990, reimbursement of legal expenses for frivolous litigation shall be denied if the action is initiated on or after November 5, 1990. Frivolous litigation is any action initiated by the nursing facility that is dismissed on the basis that no reasonable legal ground existed for the institution of such action.

§ 2.16. Documentation.

Adequate documentation supporting cost claims must be provided at the time of interim settlement, cost settlement, audit, and final settlement.

§ 2.17. Fraud and abuse.

Previously disallowed costs which are under appeal and affect more than one cost reporting period shall be disclosed in subsequent cost reports if the provider wishes to reserve appeal rights for such subsequent cost reports. The reimbursement effect of such appealed costs shall be computed by the provider and submitted to DMAS with the cost report. Where such disclosure is not made to DMAS, the inclusion of previously disallowed costs may be referred to the Medicaid Fraud Control Unit of the Office of the Attorney General.

Article 4.
New Nursing Facilities.

§ 2.18. Interim rate.

A. For all new or expanded NFs the 95% occupancy requirement shall be waived for establishing the first cost reporting period interim rate. This first cost reporting period shall not exceed 12 months from the date of the NF's certification.

B. Upon a showing of good cause, and approval of the DMAS, an existing NF that expands its bed capacity by 50% or more shall have the option of retaining its prospective rate, or being treated as a new NF.

C. The 95% occupancy requirement shall be applied to the first and subsequent cost reporting periods' actual costs for establishing such NF's second and future cost reporting periods' prospective reimbursement rates. The 95% occupancy requirement shall be considered as having been satisfied if the new NF achieved a 95% occupancy at any point in time during the first cost reporting period.

D. A new NF's interim rate for the first cost reporting period shall be determined based upon the lower of its anticipated allowable cost determined from a detailed budget (or pro forma cost report) prepared by the provider and accepted by the DMAS, or the appropriate operating ceilings or charges.

E. Any NF receiving reimbursement under new NF status shall not be eligible to receive the blended phase-in period rate under § 2.8.

F. During its first semiannual period of operation, a newly constructed or newly enrolled NF shall have an assigned SII based upon its peer group's average SII for direct patient care. An expanded NF receiving new NF treatment, shall receive the SII calculated for its last semiannual period prior to obtaining new NF status.

§ 2.19. Final rate.

The DMAS shall reimburse the lower of the appropriate operating ceilings, charges or actual allowable cost for a new NF's first cost reporting period of operation, subject to the procedures outlined above in § 2.18 A, C, E, and F.

Upon determination of the actual allowable operating cost for direct patient care and indirect patient care the per diem amounts shall be used to determine if the provider is below the peer group ceiling used to set its interim rate. If costs are below those ceilings, an efficiency incentive shall be paid at settlement of the first year cost report.

This incentive will allow a NF to be paid up to 25% of the difference between its actual allowable operating cost and the peer group ceiling used to set the interim rate. (Refer to § 2.7 F.)

Article 5.
Cost Reports.

§ 2.20. Cost report submission.

A. Cost reports are due not later than 90 days after the provider's fiscal year end. If a complete cost report is not received within 90 days after the end of the provider's fiscal year, it is considered delinquent. The cost report shall be deemed complete when DMAS has received 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 cash flows. Multi-facility providers not having individual facility financial statements shall submit the "G" series schedules from the cost report plus a statement of changes in cash flow and corporate consolidated financial statements;

4. Schedules which 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.

B. When cost reports are delinquent, the provider's interim rate shall be reduced by 20% the first month and an additional 20% of the original interim rate for each subsequent month the report has not been submitted. DMAS shall notify the provider of the schedule of reductions which shall start on the first day of the following month. For example, for a September 30 fiscal year end, notification will be mailed in early January stating that payments will be reduced starting with the first payment in February.

C. After the overdue cost report is received, desk reviewed, and a new prospective rate established, the amounts withheld shall be computed and paid. If the provider fails to submit a complete cost report within 180 days after the fiscal year end, a penalty in the amount of 10% of the balance withheld shall be forfeited to DMAS.

§ 2.21. Reporting form.

All cost reports shall be submitted on uniform reporting forms provided by the DMAS, or by Medicare if applicable. Such cost reports, subsequent to the initial cost report period, shall cover a 12-month period. Any exceptions must be approved by the DMAS.

§ 2.22. Accounting method.

The accrual method of accounting and cost reporting is mandated for all providers.

§ 2.23. Cost report extensions.

A. Extension for submission of a cost report may be granted if the provider can document extraordinary circumstances beyond its control.

B. Extraordinary circumstances do not include:

1. Absence or changes of chief finance officer, controller or bookkeeper;

2. Financial statements not completed;

3. Office or building renovations;

4. Home office cost report not completed;

5. Change of stock ownership;

6. Change of intermediary;

7. Conversion to computer; or

8. Use of reimbursement specialist.

§ 2.24. Fiscal year changes.

All fiscal year end changes must be approved 90 days prior to the beginning of a new fiscal year.

Article 6.
Prospective Rates.

§ 2.25. Time frames.

A. A prospective rate shall be determined by DMAS within 90 days of the receipt of a complete cost report. (See § 2.20 A.) Rate adjustments shall be made retroactive to the first day of the provider's new cost reporting year. Where a field audit is necessary to set a prospective rate, the DMAS shall have an additional 90 days to determine any appropriate adjustments to the prospective rate as a result of such field audit. This time period shall be extended if delays are attributed to the provider.

B. Subsequent to establishing the prospective rate DMAS shall conclude the desk audit of a providers' cost report and determine if further field audit activity is necessary. The DMAS will seek repayment or make retroactive settlements when audit adjustments are made to costs claimed for reimbursement.

Article 7.
Retrospective rates.

§ 2.26. The retrospective method of reimbursement shall be used for Mental Health/Mental Retardation facilities.

§ 2.27. (reserved)

Article 8.
Record Retention.

§ 2.28. Time frames.

A. All of the NF's accounting and related records, including the general ledger, books of original entry, and statistical data must be maintained for a minimum of five years, or until all affected cost reports are final settled.

B. Certain information must be maintained for the duration of the provider's participation in the DMAS and until such time as all cost reports are settled. Examples of such information are set forth in § 2.29.

§ 2.29. Types of records to be maintained.

Information which must be maintained for the duration of the provider's participation in the DMAS includes, but is not limited to:

1. Real and tangible property records, including leases and the underlying cost of ownership;

2. Itemized depreciation schedules;

3. Mortgage documents, loan agreements, and amortization schedules;

4. Copies of all cost reports filed with the DMAS together with supporting financial statements.

§ 2.30. Record availability.

The records must be available for audits by DMAS staff. Where such records are not available, costs shall be disallowed.

Article 9.
Audits.

§ 2.31. Audit overview.

Desk audits shall be performed to verify the completeness and accuracy of the cost report, and reasonableness of costs claimed for reimbursement. Field audits, as determined necessary by the DMAS, shall be performed on the records of each participating provider to determine that costs included for reimbursement were accurately determined and reasonable, and do not exceed the ceilings or other reimbursement limitations established by the DMAS.

§ 2.32. Scope of audit.

The scope of the audit includes, but shall not be limited to: trial balance verification, analysis of fixed assets, indebtedness, selected revenues, leases and the underlying cost of ownership, rentals and other contractual obligations, and costs to related organizations. The audit scope may also include various other analyses and studies relating to issues and questions unique to the NF and identified by the DMAS. Census and related statistics, patient trust funds, and billing procedures are also subject to audit.

§ 2.33. Field audit requirements.

Field audits shall be required as follows:

1. For the first cost report on all new NF's.

2. For the first cost report in which costs for bed additions or other expansions are included.

3. When a NF is sold, purchased, or leased.

4. As determined by DMAS desk audit.

§ 2.34. Provider notification.

The provider shall be notified in writing of all adjustments to be made to a cost report resulting from desk or field audit with stated reasons and references to the appropriate principles of reimbursement or other

appropriate regulatory cites.

§ 2.35. Field audit exit conference.

A. The provider shall be offered an exit conference to be executed within 15 days following completion of the on-site audit activities, unless other time frames are mutually agreed to by the DMAS and provider. Where two or more providers are part of a chain organization or under common ownership, DMAS shall have up to 90 days after completion of all related on-site audit activities to offer an exit conference for all such NFs. The exit conference shall be conducted at the site of the audit or at a location mutually agreeable to the DMAS and the provider.

B. The purpose of the exit conference shall be to enable the DMAS auditor to discuss such matters as the auditor deems necessary, to review the proposed field audit adjustments, and to present supportive references. The provider will be given an opportunity during the exit conference to present additional documentation and agreement or disagreement with the audit adjustments.

C. All remaining adjustments, including those for which additional documentation is insufficient or not accepted by the DMAS, shall be applied to the applicable cost report(s) regardless of the provider's approval or disapproval.

D. The provider shall sign an exit conference form that acknowledges the review of proposed adjustments.

E. After the exit conference the DMAS shall perform a review of all remaining field audit adjustments. Within a reasonable time and after all documents have been submitted by the provider, the DMAS shall transmit in writing to the provider a final field audit adjustment report (FAAR), which will include all remaining adjustments not resolved during the exit conference. The provider shall have 15 days from the date of the letter which transmits the FAAR, to submit any additional documentation which may affect adjustments in the FAAR.

§ 2.36. Audit delay.

In the event the provider delays or refuses to permit an audit to occur or to continue or otherwise interferes with the audit process, payments to the provider shall be reduced as stated in § 2.20 B.

§ 2.37. Field audit time frames.

A. If a field audit is necessary after receipt of a complete cost report, such audit shall be initiated within three years following the date of the last notification of program reimbursement and the on site activities, including exit conferences, shall be concluded within 180 days from the date the field audit begins. Where audits are performed on cost reports for multiple years or providers, the time frames shall be reasonably extended for the benefit of the DMAS and subject to the provisions of § 2.35.

B. Documented delays on the part of the provider will automatically extend the above time frames to the extent of the time delayed.

C. Extensions of the time frames shall be granted to the department for good cause shown.

D. Disputes relating to the timeliness established in §§ 2.35 and 2.37, or to the grant of extensions to the DMAS, shall be resolved by application to the Director of the DMAS or his designee.

PART III.
APPEALS.

§ 3.1. General.

A. NF's have the right to appeal the DMAS's interpretation and application of state and federal Medicaid and applicable Medicare principles of reimbursement in accordance with the Administrative Process Act, § 9-6.14.1 et seq. and § 32.1-325.1 of the Code of Virginia.

B. Nonappealable issues.

1. The use of state and federal Medicaid and applicable Medicare principles of reimbursement.

2. The organization of participating NF's into peer groups according to location as a proxy for cost variation across facilities with similar operating characteristics. The use of individual ceilings as a proxy for determining efficient operation within each peer group.

3. Calculation of the initial peer group ceilings using the most recent cost settled data available to DMAS that reflects NF operating costs inflated to September 30, 1990.

4. The use of the moving average of the Skilled Nursing Facility market basket of routine service costs, as developed by Data Resources, Incorporated, adjusted for Virginia, as the prospective escalator.

5. The establishment of separate ceilings for direct operating costs and indirect operating costs.

6. The use of Service Intensity Indexes to identify the resource needs of given NFs patient mix relative to the needs present in other NFs.

7. The development of Service Intensity Indexes based on:

a. Determination of resource indexes for each patient class that measures relative resource cost.

b. Determination of each NF's average relative resource cost index across all patients.

c. Standardizing the average relative resource cost indexes of each NF across all NF's.

8. The use of the DMAS Long Term Care Information System (LTCIS), assessment form (currently DMAS-95), Virginia Center on Aging Study, the State of Maryland Time and Motion Study of the Provision of Nursing Service in Long Term Care Facilities, and the KPMG Peat Marwick Survey of Virginia long-term care NF's nursing wages to determine the patient class system and resource indexes for each patient class.

9. The establishment of payment rates based on service intensity indexes.

§ 3.2. Conditions for appeal.

A. An appeal shall not be heard until the following conditions are met:

1. Where appeals result from desk or field audit adjustments, the provider shall have received a notification of program reimbursement (NPR) in writing from the DMAS.

2. Any and all moneys due to DMAS shall be paid in full, unless a repayment plan has been agreed to by the Director of the Division of Cost Settlement and Audit.

3. All first level appeal requests shall be filed in writing with the DMAS within 90 days following the receipt of a DMAS notice of program reimbursement that adjustments have been made to a specific cost report.

§ 3.3. Appeal procedure.

A. There shall be two levels of administrative appeal.

B. Informal appeals shall be decided by the Director of the Division of Cost Settlement and Audit after an informal fact finding conference is held. The decision of the Director of Cost Settlement and Audit shall be sent in writing to the provider within 30 days following conclusion of the informal fact finding conference.

C. If the provider disagrees with such initial decision the provider may, at its discretion, file a notice of appeal to the Director of the DMAS. Such notice shall be in writing and filed within 30 days of receipt of the initial decision.

D. Within 30 days of the receipt of such notice of appeal, the director shall appoint a hearing officer to conduct the proceedings, to review the issues and the evidence presented, and to make a written recommendation.

E. The director shall notify the provider of his final decision within 45 days of receipt of the appointed hearing officer's written recommendation, or after the parties have filed exceptions to the recommendations, whichever is later.

F. The director's final written decision shall conclude the provider's administrative appeal.

§ 3.4. Formal hearing procedures.

Formal hearing procedures, as developed by DMAS, shall control the conduct of the formal administrative proceedings.

§ 3.5. Appeals time frames.

Appeal time frames noted throughout this section may be extended for the following reasons;

A. The provider submits a written request prior to the due date requesting an extension for good cause and the DMAS approves the extension.

B. Delays on the part of the NF documented by the DMAS shall automatically extend DMAS's time frame to the extent of the time delayed.

C. Extensions of time frames shall be granted to the DMAS for good cause shown.

D. When appeals for multiple years are submitted by a NF or a chain organization or common owners are coordinating appeals for more than one NF, the time frames shall be reasonably extended for the benefit of the DMAS.

E. Disputes relating to the time lines established in § 3.3 B or to the grant of extensions to the DMAS shall be resolved by application to the Director of the DMAS or his designee.

PART IV.
INDIVIDUAL EXPENSE LIMITATION.

In addition to operating costs being subject to peer group ceilings, costs are further subject to maximum limitations as defined in VR 460-03-4.1943, Cost Reimbursement Limitations.

PART V.
COST REPORT PREPARATION INSTRUCTIONS.

Instructions for preparing NF cost reports will be provided by the DMAS.

PART VI.
STOCK TRANSACTIONS.

§ 6.1. Stock acquisition.

The acquisition of the capital stock of a provider does not constitute a basis for revaluation of the provider's assets. Any cost associated with such an acquisition shall not be an allowable cost. The provider selling its stock continues as a provider after the sale, and the purchaser is only a stockholder of the provider.

§ 6.2. Merger of unrelated parties.

A. In the case of a merger which combines two or more unrelated corporations under the regulations of the Code of Virginia, there will be only one surviving corporation. If the surviving corporation, which will own the assets and liabilities of the merged corporation, is not a provider, a Certificate of Public Need, if applicable, must be issued to the surviving corporation.

B. The nonsurviving corporation shall be subject to the policies applicable to terminated providers, including those relating to gain or loss on sales of NFs.

§ 6.3. Merger of related parties.

The statutory merger of two or more related parties or the consolidation of two or more related providers resulting in a new corporate entity shall be treated as a transaction between related parties. No revaluation shall be permitted for the surviving corporation.

PART VII.
NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAM AND COMPETENCY EVALUATION PROGRAMS (NATCEPs).

§ 7.1. The Omnibus Budget Reconciliation Act of 1989 (OBRA 89) amended § 1903(a)(2)(B) of the Social Security Act to fund actual NATCEPs costs incurred by NFs separately from the NF's medical assistance services reimbursement rates.

§ 7.2. NATCEPs costs.

A. NATCEPs costs shall be as defined in VR 460-03-4.1941.

B. To calculate the reimbursement rate, NATCEPs costs contained in the most recently filed cost report shall be converted to a per diem amount by dividing allowable NATCEPs costs by the actual number of NF's patient days.

C. The NATCEPs interim reimbursement rate determined in § 7.2 B shall be added to the prospective operating cost and plant cost components or charges, whichever is lower, to determine the NF's prospective rate. The NATCEPs interim reimbursement rate shall not be adjusted for inflation.

D. Reimbursement of NF costs for training and competency evaluation of nurse aides must take into account the NF's use of trained nurse aides in caring for Medicaid, Medicare and private pay patients. Medicaid shall not be charged for that portion of NATCEPs costs which are properly charged to Medicare or private pay services. The final retrospective reimbursement for NATCEPs costs shall be the reimbursement rate as calculated from the most recently filed cost report by the methodology in § 7.2 B times the Medicaid patient days from the DMAS MMR-240.

E. Disallowance of nonreimbursable NATCEPs costs shall be reflected in the year in which the nonreimbursable costs were claimed.

F. Payments to providers for allowable NATCEPs costs shall not be considered in the comparison of the lower allowable reimbursement or charges for covered services, as outlined in § 2.14 A.

PART VIII.
(Reserved)

PART IX.
USE OF MMR-240.

All providers must use the data from computer printout MMR-240 based upon a 60-day accrual period.

PART X.
COMMINGLED INVESTMENT INCOME.

DMAS shall treat funds commingled for investment purposes in accordance with PRM-15, § 202.6.

PART XI.
PROVIDER NOTIFICATION.

DMAS shall notify providers of State Plan changes affecting reimbursement 30 days prior to the enactment of such changes.

PART XII.
START-UP COSTS AND ORGANIZATIONAL COSTS.

§ 12.1. Start-up costs.

A. In the period of developing a provider's ability to furnish patient care services, certain costs are incurred. The costs incurred during this time of preparation are referred to as start-up costs. Since these costs are related to patient care services rendered after the time of preparation, they shall be capitalized as deferred charges and amortized over a 60-month time frame.

B. Start-up costs may include, but are not limited to, administrative and nursing salaries; heat, gas, and electricity; taxes, insurance; employee training costs; repairs and maintenance; housekeeping; and any other allowable costs incident to the start-up period. However, any costs that are properly identifiable as operating costs must be appropriately classified as such and excluded from start-up costs.

C. Start-up costs that are incurred immediately before a provider enters the Program and that are determined by the provider, subject to the DMAS approval, to be immaterial need not be capitalized but rather may be charged to operations in the first cost reporting period.

D. Where a provider incurs start-up costs while in the Program and these costs are determined by the provider, subject to the DMAS approval, to be immaterial, these costs shall not be capitalized but shall be charged to operations in the periods incurred.

§ 12.2. Applicability.

A. Start-up cost time frames.

1. Start-up costs are incurred from the time preparation begins on a newly constructed or purchased building, wing, floor, unit, or expansion thereof to the time the first patient (whether Medicaid or non-Medicaid) is admitted for treatment, or where the start-up costs apply only to nonrevenue producing patient care functions or nonallowable functions, to the time the areas are used for their intended purposes.

2. If a provider intends to prepare all portions of its entire facility at the same time, start-up costs for all portions of the facility shall be accumulated in a single deferred charge account and shall be amortized when the first patient is admitted for treatment.

3. If a provider intends to prepare portions of its facility on a piecemeal basis (i.e., preparation of a floor or wing of a provider's facility is delayed), start-up costs shall be capitalized and amortized separately for the portion or portions of the provider's facility prepared during different time periods.

4. Moreover, if a provider expands its NF by constructing or purchasing additional buildings or wings, start-up costs shall be capitalized and amortized separately for these areas.

B. Depreciation time frames.

1. Costs of the provider's facility and building equipment shall be depreciated using the straight line method over the lives of these assets starting with the month the first patient is admitted for treatment.

2. Where portions of the provider's NF are prepared for patient care services after the initial start-up period, those asset costs applicable to each portion shall be depreciated over the remaining lives of the applicable assets. If the portion of the NF is a nonrevenue-producing patient care area or nonallowable area, depreciation shall begin when the area is opened for its intended purpose. Costs of major movable equipment, however, shall be depreciated over the useful life of each item starting with the month the item is placed into operation.

§ 12.3. Organizational costs.

A. Organizational costs are those costs directly incident to the creation of a corporation or other form of business. These costs are an intangible asset in that they represent expenditures for rights and privileges which have a value to the enterprise. The services inherent in organizational costs extend over more than one accounting period and thus affect the costs of future periods of operations.

B. Allowable organizational costs shall include, but not be limited to, legal fees incurred in establishing the corporation or other organization (such as drafting the corporate charter and by-laws, legal agreements, minutes of organizational meeting, terms of original stock certificates), necessary accounting fees, expenses of temporary directors and organizational meetings of directors and stockholders and fees paid to states for incorporation.

C. The following types of costs shall not be considered allowable organizational costs: costs relating to the issuance and sale of shares of capital stock or other securities, such as underwriters fees and commissions, accountant's or lawyer's fees, cost of qualifying the issues with the appropriate state or federal authorities, stamp taxes, etc.

D. Allowable organization costs shall generally be capitalized by the organization. However, if DMAS concludes that these costs are not material when compared to total allowable costs, they may be included in allowable indirect operating costs for the initial cost reporting period. In all other circumstances, allowable organization costs shall be amortized ratably over a period of 60 months starting with the month the first patient is admitted for treatment.

PART XIII.
DMAS AUTHORIZATION.

§ 13.1 Access to records.

A. DMAS shall be authorized to request and review, either through a desk or field audit, all information related to the provider's cost report that is necessary to ascertain the propriety and allocation of costs (in accordance with Medicare and Medicaid rules, regulations, and limitations) to patient care and nonpatient care activities.

B. Examples of such information shall include, but not be limited to, all accounting records, mortgages, deeds, contracts, meeting minutes, salary schedules, home office services, cost reports, and financial statements.

C. This access also applies to related organizations as defined in § 2.10 who provide assets and other goods and services to the provider.

PART XIV.
HOME OFFICE COSTS.

§ 14.1. General.

Home office costs shall be allowable to the extent they are reasonable, relate to patient care, and provide cost savings to the provider.

§ 14.2. Purchases.

Provider purchases from related organizations, whether for services, or supplies, shall be limited to the lower of the related organizations actual cost or the price of comparable purchases made elsewhere.

§ 14.3. Allocation of home office costs.

Home office costs shall be allocated in accordance with § 2150.3, PRM-15.

§ 14.4. Nonrelated management services.

Home office costs associated with providing management services to nonrelated entities shall not be recognized as allowable reimbursable cost.

§ 14.5. Allowable and nonallowable home office costs.

Allowable and nonallowable home office costs shall be recognized in accordance with § 2150.2, PRM-15.

§ 14.6. Equity capital.

Item 398 D of the 1987 Appropriation Act (as amended), effective April 8, 1987, eliminated reimbursement of return on equity capital to proprietary providers for periods or portions thereof on or after July 1, 1987.

PART XV.
REFUND OF OVERPAYMENTS.

§ 15.1. Lump sum payment.

When the provider files a cost report indicating that an overpayment has occurred, full refund shall be remitted with the cost report. In cases where DMAS discovers an overpayment during desk audit, field audit, or final settlement, DMAS shall promptly send the first demand letter requesting a lump sum refund. Recovery shall be undertaken even though the provider disputes in whole or in part DMAS' determination of the overpayment.

§ 15.2. Offset.

If the provider has been overpaid for a particular fiscal year and has been underpaid for another fiscal year, the underpayment shall be offset against the overpayment. So long as the provider has an overpayment balance, any underpayments discovered by subsequent review or audit shall be used to reduce the balance of the overpayment.

§ 15.3. Payment schedule.

A. If the provider cannot refund the total amount of the overpayment (i) at the time it files a cost report indicating that an overpayment has occurred, the provider shall request in writing an extended repayment schedule at the time of filing, or (ii) within 30 days after receiving the DMAS demand letter, the provider shall promptly request in writing an extended repayment schedule.

B. DMAS may establish a repayment schedule of up to 12 months to recover all or part of an overpayment or, if a provider demonstrates that repayment within a 12-month period would create severe financial hardship, the Director of DMAS may approve a repayment schedule of up to 36 months.

C. A provider shall have no more than one extended repayment schedule in place at one time. If subsequent audits identify additional overpayment, the full amount shall be repaid within 30 days unless the provider submits further documentation supporting a modification to the existing extended repayment schedule to include the additional amounts.

D. If, during the time an extended repayment schedule is in effect, the provider ceases to be a participating provider or fails to file a cost report in a timely manner, the outstanding balance shall become immediately due and payable.

E. When a repayment schedule is used to recover only part of an overpayment, the remaining amount shall be recovered from interim payments to the provider or by lump sum payments.

§ 15.4. Extension request documentation.

In the written request for an extended repayment schedule, the provider shall document the need for an extended (beyond 30 days) repayment and submit a written proposal scheduling the dates and amounts of repayments. If DMAS approves the schedule, DMAS shall send the provider written notification of the approved repayment schedule, which shall be effective retroactive to the date the provider submitted the proposal.

§ 15.5. Interest charge on extended repayment.

A. Once an initial determination of overpayment has been made, DMAS shall undertake full recovery of such overpayment whether or not the provider disputes, in whole or in part, the initial determination of overpayment. If an appeal follows, interest shall be waived during the period of administrative appeal of an initial determination of overpayment.

B. Interest charges on the unpaid balance of any overpayment shall accrue pursuant to § 32.1-313 of the Code of Virginia from the date the director's determination becomes final.

C. The director's determination shall be deemed to be

final on (i) the due date of any cost report filed by the provider indicating that an overpayment has occurred, or (ii) the issue date of any notice of overpayment, issued by DMAS, if the provider does not file an appeal, or (iii) the issue date of any administrative decision issued by DMAS after an informal fact finding conference, if the provider does not file an appeal, or (iv) the issue date of any administrative decision signed by the director, regardless of whether a judicial appeal follows. In any event, interest shall be waived if the overpayment is completely liquidated within 30 days of the date of the final determination. In cases in which a determination of overpayment has been judicially reversed, the provider shall be reimbursed that portion of the payment to which it is entitled, plus any applicable interest which the provider paid to DMAS.

PART XVI.
REVALUATION OF ASSETS.

§ 16.1. Change of ownership.

A. Under the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law 99-272, reimbursement for capital upon the change of ownership of a NF is restricted to the lesser of:

1. One-half of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership), in the Dodge Construction Cost Index applied in the aggregate with respect to those facilities that have undergone a change of ownership during the fiscal year, or

2. One-half of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership) in the Consumer Price Index for All Urban Consumers (CPI-U) applied in the aggregate with respect to those facilities that have undergone a change of ownership during the fiscal year.

B. To comply with the provisions of COBRA 1985, effective October 1, 1986, the DMAS shall separately apply the following computations to the capital assets of each facility which has undergone a change of ownership:

1. One-half of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership), in the Dodge Construction Cost Index, or

2. One-half of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership) in the Consumer Price Index for All Urban Consumers (CPI-U).

C. Change of ownership is deemed to have occurred only when there has been a bona fide sale of assets of a NF (See § 2.5 B 3 for the definition of "bona fide" sale).

D. Reimbursement for capital assets which have been revalued when a facility has undergone a change of ownership shall be limited to the lesser of:

1. The amounts computed in subsection B above;

2. Appraised replacement cost value; or

3. Purchase price.

E. Date of acquisition is deemed to have occurred on the date legal title passed to the seller. If a legal titling date is not determinable, date of acquisition shall be considered to be the date a certificate of occupancy was issued by the appropriate licensing or building inspection agency of the locality where the nursing facility is located.

* * *

NOTICE: The forms used in administering the above regulations are not being published due to the large number; however, the name of each form is listed below. The forms are available for public inspection at the Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia, or at the Office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Room 262, Richmond, Virginia.

Nursing Facility Uniform Cost Report Under Title XIX - Facility Description and Statistical Data (Schedule A)
Certification by Officer or Administrator of Provider (Schedule A-2)
Reclassification and Adjustment of Trial Balance of Expenses (Schedule B)
Classifications (Schedule B-1)
Analysis of Administrative and General - Other (Schedule B-2)
Adjustment to Expenses (Schedule B-4)
Cost Allocation - Employee Benefits (Schedule B-5)
Computation of Title XIX Direct Patient Care Ancillary Service Costs (Schedule C)
Statement of Cost of Services and Related Organizations (Schedule D)
Statement of Compensation of Owners (Schedule E)
Part II Statement of Compensation Administrators and/or Assistant Administrators (Schedule F)
Balance Sheet (Schedule G)
Statement of Patient Revenues (Schedule G-1)
Statement of Operations (Schedule G-2)
Computation of Title XIX (Medicaid) Base Costs and Prospective Rate/PIRS (Schedule H)
Computation of Prospective Direct and Indirect Patient Care Profit Incentive Rates (Schedule H-1)
Calculation of Medical Service Reimbursement Settlement (Schedule J)
Calculation of NATCEPs Reimbursement Settlement (Schedule J-1)
Debt and Interest Expenses (Schedule K)
Limitation on Federal Participation for Capital Expenditures Questionnaire (Schedule L)

Nurse Aide Training and Competency Evaluation Program Costs and Competency Evaluation Programs (NATCEPs) (Schedule N)
Certification by Officer or Administrator of Provider (Schedule A-1)
Skilled Nursing Facility and Skilled Nursing Facility Health Care Complex Statistical Data (Worksheet S-3)
Reclassification and Adjustment of Trial Balance of Expenses (Worksheet A)
Reclassification (Worksheet A-6)
Adjustments to Expenses (Worksheet A-8)
Statement of Costs of Services from Related Organizations (Supplemental Worksheet A-8)
Cost Allocation - General Service Costs (Worksheet B, Part I)
Cost Allocation - Statistical Basis (Worksheet B-1)
Allocation of Capital-Related Costs (Worksheet B, Part II)
Departmental Cost Distribution (Worksheet C)
Computation of Patient Intensity Reimbursement System Base Operating Costs (Schedule A-3)
Computation of Direct Patient Care Nursing Service Costs (Schedule A-4)

* * * * * * * *

Title of Regulation: **VR 460-03-4.1921. Pediatric and Obstetric Services Maximum Payments.**

Statutory Authority: § 32.1-325 of the Code of Virginia.

Effective Date: July 1, 1992.

Summary:

The purpose of this amendment is to promulgate permanent regulations in conformance to OBRA '89 § 6402 and to new American Medical Association procedure codes. This regulatory action makes no fee changes but merely changes the coding convention used by physicians on billing forms to identify the procedures performed.

Attachment 4.19 B of the Plan contains reimbursement methodologies for all covered services except for inpatient hospital and long-term care, which are covered in other Plan attachments. This amendment modifies Supplement 1 to Attachment 4.19 B, providing obstetric and pediatric payment rates, in conformance with the OBRA 89 requirement.

DMAS uses the American Medical Association's (AMA) Physicians' Current Procedural Terminology coding system for bills for physicians' services. Effective January 1, 1992, the AMA changed its coding system from one of identifying specific office visits to a system of evaluation and management codes. In order to conform its Plan to the 1989 requirements of OBRA § 6402 and to accommodate the recent AMA changes, DMAS must modify the procedure codes and concomitant descriptions contained in Supplement 1 to Attachment 4.19 B.

VR 460-03-4.1921. Pediatric and Obstetric Services Maximum Payments.

~~CPT-4 Code~~	~~Description~~	~~Payment~~
	~~PEDIATRIC SERVICES~~	
	~~1. Office Medical Services. Physician services performed in an office and nonemergency services performed in other settings (e.g., emergency departments of hospitals).~~	
	~~NEW PATIENT~~	
~~90000~~	~~Office medical service, new patient, brief service~~	~~$ 24.00~~
~~90010~~	~~limited service~~	~~28.00~~
~~90015~~	~~intermediate service~~	~~33.00~~
~~90017~~	~~extended service~~	~~40.00~~
~~90020~~	~~comprehensive service~~	~~50.00~~
	~~ESTABLISHED PATIENT~~	
~~90030~~	~~Office medical service, established patient, minimal service~~	~~$ 10.00~~
~~90040~~	~~brief service~~	~~19.00~~
~~90050~~	~~limited service~~	~~24.00~~
~~90060~~	~~intermediate service~~	~~28.00~~
~~90070~~	~~extended service~~	~~35.00~~
~~90080~~	~~comprehensive service~~	~~45.00~~
	~~2. Emergency Department Services. For emergency care.~~	
	~~NEW PATIENT~~	
~~90500~~	~~Emergency department service, new patient, minimal service~~	~~$ 18.00~~
~~90505~~	~~brief service~~	~~34.00~~
~~90510~~	~~limited service~~	~~44.00~~
~~90515~~	~~intermediate service~~	~~55.00~~
~~90517~~	~~extended service~~	~~78.00~~
~~90520~~	~~comprehensive service~~	~~102.00~~
	~~ESTABLISHED PATIENT~~	
~~90530~~	~~Emergency department services, established patient, minimal service~~	~~15.00~~
~~90540~~	~~brief service~~	~~25.00~~
~~90550~~	~~limited service~~	~~35.00~~
~~90560~~	~~intermediate service~~	~~40.00~~
~~90570~~	~~extended service~~	~~51.00~~
~~90580~~	~~comprehensive service~~	~~69.00~~
	~~3. Immunization Injections.~~	
~~90701~~	~~Immunization, active, diptheria and tetanus toxoids and pertussis vaccine (DTP)~~	~~$ 17.91~~
~~90702~~	~~diphtheria and tetanus toxoids (DT)~~	~~3.99~~
~~90704~~	~~mumps virus vaccine, live~~	~~10.35~~
~~90705~~	~~measles virus vaccine, live, attenuated~~	~~14.68~~

90706	rubella virus vaccine, live	15.19
90707	measles, mumps and rubella virus vaccine, live	29.97
90708	measles and rubella virus vaccine, live	21.23
90709	rubella and mumps virus vaccine, live	22.76
90712	poliovirus vaccine, live, oral (any type(s))	11.72
90737	Hemophilus influenza B	18.45

Note: appropriate office visit may be billed in addition to the above immunization injections

4. Preventive Medicine:

NEW PATIENT

90751	Initial history and examination related to the healthy individual, including anticipatory guidance, adolescent (age 12 through 17 years)	$ 35.00
90752	late childhood (age 5 through 11 years)	39.00
90753	early childhood (age 1 through 4 years)	39.00
90754	infant (age under 1 year)	30.00
90755	Infant care to one year of age with a maximum of 12 office visits during regular office hours, including tuberculin skin testing and immunization of DTP and oral polio	29.00
90757	Newborn care, in other than hospital setting, including physical examination of baby and conference(s) with parent(s)	33.00

ESTABLISHED PATIENT

90781	Interval history and examination, related to the healthy individual, including anticipatory guidance, periodic type of examination, adolescent (age 12 through 17 years)	$ 31.00
90782	late childhood (age 5 though 11 years)	36.00
90783	early childhood (age 1 through 4 years)	36.00
90784	infant (age under 1 year)	35.00
90774	Administration and medical interpretation of developmental tests	18.00
90778	Circadian respiratory pattern recording (pediatric pneumogram), 12 to 24 hour continuous recording, infant	10.00

OBSTETRICAL SERVICES

1. Maternity Care and Delivery:

INCISION

59020	Fetal oxytocin stress test	$ 60.00
59025	Fetal nonstress test	50.00
59030	Fetal scalp blood sampling,	66.00
	repeat	22.25
59050	Initiation and/or supervision of internal fetal monitoring during labor by consultant	50.00

REPAIR

59300	Episiotomy or vaginal repair only, by other than attending physician	250.00

DELIVERY, ANTEPARTUM AND POSTPARTUM CARE

59400	Total ob. care (all-inclusive, "global" care) includes antepartum care, vaginal delivery (with or without episiotomy, and/or forceps or breech delivery) and postpartum care	$1200.00
59410	Vaginal delivery only (with or without episiotomy, forceps or breech delivery) including in-hospital postpartum care (separate procedure)	864.00
59412	External cephalic version, with or without tocolysis	250.00
59420	Antepartum care only (separate procedure)	300.00
59430	Postpartum care only (separate procedure)	33.00

CESAREAN SECTION

59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care	$1441.00
59515	Cesarean delivery only including postpartum care	1134.00
59525	Subtotal or total hysterectomy after cesarean delivery	383.00

ABORTION

59812	Treatment of spontaneous abortion, any trimester, completed surgically	450.00
59820	Treatment of missed, abortion completed surgically, first trimester	442.00
59830	Treatment of septic abortion completed surgically	229.15

2. Diagnostic Ultrasound:

PELVIS

76805	Echography, pregnant uterus, B-scan and/or real time with image documentation complete	$ 98.00
76815	limited (fetal growth rate, heart beat, anomalies, placental location)	70.00
76816	follow-up or repeat	45.00
76818	Fetal biophysical profile	75.00
76825	Echocardiography, fetal heart in utero	92.50
76855	Echography, pelvic area (Doppler)	145.00

PEDIATRIC SERVICES

CPT-4 Code	*Description*	*Payment*

1. Evaluation and Management Services - Physician services performed in a physician's office or in an outpatient facility

NEW PATIENT

99201	Problem focused history, examination, and straigtforward medical decision making	$24.00
99202	Expanded problem focused history, examination, straightforward medical decision making	28.00
99203	Detailed history, examination and straightforward medical decision making of moderate complexity	33.00
99204	Comprehensive history, examination, and medical decision making of moderate complexity	46.75
99205	Comprehensive history, examination and medical decision of high complexity	50.00

ESTABLISHED PATIENT

99211	Minimal presenting problems	$10.00
99212	Problem focused history, or examination, and straightforward medical decision making	19.00
99213	Expanded problem focused history or examination, and medical decision of low complexity	26.50
99214	Detailed history, or examination, and medical decision making of moderate complexity	35.00
99215	Comprehensive history, or examination and medical decision of high complexity	45.00

2. Emergency Department Services for emergency care

NEW OR ESTABLISHED PATIENT

99281	Problem focused history, examination and straightforward medical decision making	$26.60
99282	Expanded problem focused history examination and medical decision making of low complexity	46.60
99283	Expanded problem focused history, examination, and medical making decision of low to moderate complexity	49.60
99284	Detailed history, examination, and medical decision making of moderate complexity	57.30
99285	Comprehensive history Comprehensive examination Medical decision making of high complexity	81.40

3. Immunization Injections*

90701	Immunization, active; diptheria and tetanus toxoids and pertussis vaccine (DTP)	$ drug cost
90702	Diptheria and tetanus toxoids (DT)	$ drug cost
90704	Mumps virus vaccine, live	$ drug cost
90705	Measles virus vaccine, live, attenuated	$ drug cost
90706	Rubella virus vaccine, live	$ drug cost
90707	Measles, mumps and rubella virus vaccine, live	$ drug cost
90708	Measles and rubella virus vaccine, live	$ drug cost
90709	Rubella and mumps virus vaccine, live	$ drug cost
90712	Poliovirus vaccine, live, oral (any type(s))	$ drug cost
90737	Hemophilus influenza B	$ drug cost

* (Note: Appropriate office visit may be billed in addition to the above immunization injections. Payment for immunizations shall not exceed the Medicaid fee on file for the drug at time of service.)

4. Preventive Medicine

NEW PATIENT

99381	Initial evaluation and management of a healthy individual requiring a comprehensive history, a comprehensive examination, the identification of risk factors, and the ordering of appropriate laboratory/diagnostic procedures; infant (age under 1 year)	$35.00
99382	Early childhood (age 1 through 4 years)	39.00
99383	Late childhood (age 5 through 11 years)	39.00
99384	Adolescent (age 12 through 17 years)	35.00

ESTABLISHED PATIENT

99391	Periodic evaluation and management of a healthy individual requiring a comprehensive history, a comprehensive examination, the identification of risk factors, and the ordering of appropriate	$35.00

	laboratory/diagnostic procedures; infant (age under 1 year)	
99392	Early childhood (age 1 through 4 years	36.00
99393	Late childhood (age 5 through 11 years)	36.00
99394	Adolescent (age 12 through 17 years	31.00

OBSTETRICAL SERVICES

1. Maternity Care and Delivery

INCISION

59020	Fetal oxytocin street test	$60.00
59025	Fetal non-stress test	50.00
59030	Fetal scalp blood sampling	66.00
59050	Initiation and/or supervision of internal fetal monitoring during labor by consultant	50.00

REPAIR

59300	Episiotomy or vaginal repair, by other than attending physician	$250.00

DELIVERY, ANTEPARTUM AND POSTPARTUM CARE

59400	Total ob. care (all-inclusive, ''global'' care) includes antepartum care, vaginal delivery (with or without episiotomy, and/or forceps or breech delivery) and postpartum care	$1,200.00
59410	Vaginal delivery only (with or without episiotomy, forceps or breech delivery) including in-hospital postpartum care (separate procedure)	864.00

OBSTETRICAL SERVICES

59412	External cephalic version, with or without tocolysis	$250.00
59420	Antepartum care only (separate procedure)	300.00
59430	Postpartum care only (separate procedure)	36.00

CESAREAN SECTION

59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care	$1,441.00
59515	Cesarean delivery only including postpartum care	1,134.00
59525	Subtotal or total hysterectomy after cesarean delivery	383.00

ABORTION

59812	Treatment of spontaneous abortion, any trimester, completed surgically	$475.00
59820	Treatment of missed abortion, completed surgically; first trimester	442.00
59830	Treatment of septic abortion completed surgically	229.15

2. Diagnostic Ultrasound

PELVIS

76805	Echography, pregnant uterus, B-scan and/or real time with image documentation; complete (complete fetal and maternal evaluation)	$90.00
76810	Complete (complete fetal and maternal evaluation), multiple gestation, after the first trimester	180.00
76815	Limited (gestation age,) heart beat, placental location, fetal position, or emergency in the delivery room)	60.00
76816	Follow-up or repeat	45.00
76818	Fetal biophysical profile	75.00
76825	Echocardiography, fetal, real time with image documentation (2D) with or without M-mode recording	90.00

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

REGISTRAR OF REGULATIONS

9 FEB 12 PM 4:16

HEALTH INSURANCE CLAIM FORM

PICA

PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA 1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

DEPARTMENT OF STATE POLICE

REGISTRAR'S NOTICE: Due to its length, the full text of the regulation filed by the Department of State Police is not being published; however, the amendment to subdivision 13 of § 21 is being published. In accordance with § 9-6.14:22 of the Code of Virginia, a summary is being published in lieu of the full text. The full text of the regulation is available for public inspection at the office of the Registrar of Regulations and at the Department of State Police.

Title of Regulation: **VR 545-01-07. Motor Vehicle Safety Inspection Rules and Regulations.**

Statutory Authority: §§ 46.2-1002, 46.2-1163 and 46.2-1165 of the Code of Virginia.

Effective Date: July 1, 1992.

Summary:

This amendment permits vehicles to be equipped with tinted or colored ventvisors that do not extend more than two inches into the driver's viewing area.

VR 545-01-07. Motor Vehicle Safety Inspection Rules and Regulations.

13. Front side windows have cloudiness above three inches from the bottom of the glass, or other defects that affect the driver's vision or one or more cracks which permit one part of the glass to be moved in relation to another part. Wind silencers, breezes or other ventilator adaptors are not made of clear transparent material.

a. EXCEPTION: Colored or tinted ventvisors that do not exceed more than two inches from the forward door post into the driver's viewing area are permitted.

DEPARTMENT OF SOCIAL SERVICES (BOARD OF)

Title of Regulation: **VR 615-45-2. Child Protective Services Client Appeals.**

Statutory Authority: §§ 63.1-25 and 63.1-248.6:1 of the Code of Virginia.

Effective Date: July 1, 1992.

Summary:

The amendments to the Child Protective Services Client Appeals Regulations are intended to (i) clarify the timeframe in which an appellant has to request an administrative hearing; (ii) delete the policy which allows the appellant the right to waive the timeframe for scheduling the local conference; (iii) extend the timeframe in which the administrative decision is written; and (iv) clarify the responsibilities of the local department upon receipt of the hearing officer's decision.

VR 615-45-2. Child Protective Services Client Appeals.

PART I.
DEFINITIONS.

§ 1.1. The following words and terms, when used in these regulations, shall have the following meaning, unless the context clearly indicates otherwise:

"Alleged abuser" means any person who is the subject of a child protective services complaint and is suspected of or is found to have committed the abuse or neglect of a child pursuant to § 63.1-248 et seq. of the Code of Virginia.

"Child protective services" means the identification, receipt and immediate investigation of complaints and reports of child abuse and neglect for children under 18 years of age. It also includes documenting, arranging for, and providing social casework and other services for the child, his family, and the alleged abuser.

"Complaint" means a valid report of suspected child abuse/neglect which must be investigated by the local department of social services.

"Final disposition" means the determination of founded, reason to suspect, or unfounded made on each complaint by the investigating worker.

"Founded" means that a review of the facts shows clear and convincing evidence that child abuse or neglect has occurred.

"Reason to suspect" means that a review of the facts shows no clear and convincing evidence that abuse or neglect has occurred. However, the situation gives the worker reason to believe that abuse or neglect has occurred.

"Unfounded" means that a review of the facts shows no reason to believe that abuse or neglect has occurred.

PART II.
POLICY.

§ 2.1. Appeal process.

Appeal is the process by which the alleged abuser may request amendment of the record in situations where the investigation has resulted in a "founded" or "reason to suspect" disposition.

A. Final disposition.

The investigating agency shall notify the alleged abuser

of its disposition of the investigation in writing to be mailed to the alleged abuser by mail as provided in Vol. VII, Section III, Chapter A ~~of the Social Services Policy Manual~~ , *Services Manual, Virginia Department of Social Services* . The notice shall state the finding as "founded" or "reason to suspect" and outline the rights of appeal and the right to review the case record pursuant to the Virginia Privacy Protection Act of 1976 (§ 2.1-377 et seq. of the Code of Virginia).

B. Local conference.

1. The purpose and goal of the local conference is to allow the appellant, his representative and the agency an opportunity to meet informally in an effort to:

a. Resolve their differences about the disposition of the CPS investigation,

b. Explore fully the agency's disposition and reasons for it,

c. Explore fully the alleged abuser's additional information about the investigation and disposition,

d. Facilitate treatment with the family and alleged abuser by encouraging informal dispute resolution.

2. A request to amend the record must be made in writing to the local director within 30 days of receipt of the agency notice by the alleged abuser. The local department shall stamp the date of receipt on the request. The local department shall also notify the Child Abuse/Neglect Central Registry that an appeal is pending.

3. The local director or his designee shall arrange a convenient time for an informal conference with the appellant. Participants in the conference will include the appellant and, if the appellant chooses, his authorized representative, and the worker who made the disposition on the case. The local director or his designee shall preside during the conference; a designee must be a staff member to whom the worker who made the disposition is subordinate.

4. Prior to the informal conference, the appellant shall have the opportunity to review the case record pursuant to the Virginia Privacy Protection Act of 1976.

5. During the informal conference, the appellant may submit any additional documentation or arguments that he deems relevant to the disposition. Such documentation shall become part of the case record.

6. The director or his designee shall issue a written decision as a result of the informal conference within 30 days of receipt of the written request from the appellant. The written decision shall prescribe:

a. What action will be taken on the request for amendment, and

b. What further appeal rights exist.

The written decision shall be mailed to the appellant.

7. As a result of the local conference, the local director or his designee may amend the final disposition and case record.

~~8. The appellant may waive the time deadline for scheduling the local conference.~~

C. Administrative hearing.

1. The appellant may request in writing that the commissioner ~~provide~~ *grant* an administrative hearing to review the request for amendment *if* :

a. ~~If~~ The local department ~~fails to render a decision within 30 days of a request by an appellant;~~ *refuses to amend its report (disposition);* or

b. ~~Within 30 days of the receipt of an unfavorable written decision of the informal conference~~ *The local department fails to act within 30 days after receiving such request.*

Such requests must be made within 30 days thereafter .

2. The commissioner shall appoint a hearing officer to conduct an administrative hearing to review the request for amendment of the disposition and case record.

3. Hearing officer's powers and responsibilities.

a. The hearing officer shall set a convenient time within 45 days of appellant's request for the parties involved to conduct the hearing. The hearing officer may reschedule the hearing upon good cause. Appellant may waive time deadlines.

b. The hearing officer has no subpoena power [~~or~~ *nor*] authority to administer oaths or affirmations.

c. The hearing officer may accept all relevant evidence submitted during the hearing [,] and shall not be bound by strict rules of evidence.

d. Either party may have the hearing recorded by a court reporter. The hearing officer shall make or cause to be made an audio recording of the entire hearing [,] a copy of which shall be available to either party.

e. The hearing officer may defer his decision for a specified period not to exceed 14 days after conclusion of the hearing in order for either party

to present additional evidence.

f. The hearing officer may examine any witness and give the appellant and the local department an opportunity to examine any witness.

4. Hearing procedure.

a. All persons present shall be identified on the record. The appellant may be accompanied by an authorized representative.

b. The hearing officer shall explain the purpose of the hearing and the procedures that will be followed. The hearing officer shall state that the appellant must prove by a preponderance of the evidence that the case record should be amended because it contains information which is irrelevant or inaccurate.

c. The local department will submit a copy of all material in the local agency's case record which contains information and documentation used to make the determination of "founded" or "reason to suspect" in the case being appealed, which shall be accepted into evidence by the hearing officer.

d. The appellant will state his objections to the disposition reached by the local department and summarize the evidence supporting his conclusion. The appellant may submit any further relevant evidence.

5. Hearing decision.

a. Within ~~30~~ *60* days of the close of receiving evidence in the hearing, the hearing officer shall render a written decision which shall be mailed to the appellant by certified mail, return receipt requested. A copy of the decision shall be mailed to the local department by first class mail.

b. The decision of the hearing officer shall state:

(1) Findings of fact;

(2) Conclusions based on law and regulation;

(3) Final disposition of the case[,] and action to be taken on appellant's request to amend the disposition or case record;

(4) Right to judicial review.

D. Final action.

Upon receipt of the hearing officer's decision, the local department shall amend the [~~case~~] record ~~and~~ . The *department shall amend the* Child Abuse/Neglect Central Registry report in accordance with the decision. ~~Notification shall be made to the Child Abuse/Neglect Central Registry.~~

All prior recipients of the record or the findings shall be notified of the hearing officer's decision to amend or expunge the record. This notification shall be the responsibility of the local agency except for the notification to the appellant. The hearing officer will notify the appellant directly.

DEPARTMENT OF THE TREASURY (STATE TREASURER)

Title of Regulation: **VR 640-04-1. Regulations Governing Escheats.**

Statutory Authority: § 55-200.1 of the Code of Virginia.

Effective Date: July 1, 1992.

Summary:

The regulations address the annual reporting requirements for local government treasurers and escheators and outline the escheator's responsibilities for the disclosures to be made at escheat auctions, the collection and remittance of sale proceeds, and the notifications to be made to defaulting purchasers. In addition, the regulations stipulate the required bonding for escheators, specify the commission basis for escheators and auctioneers as well as the reimbursable expenses of auctioneers, and outline department charges for requests for information under the Freedom of Information Act.

VR 640-04-1. Regulations Governing Escheats.

§ 1. Definitions.

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

"Agency" means the Department of the Treasury.

"Escheator" means any individual who has been appointed and qualified, and who continues in service in accordance with §§ 55-168 through 55-170 of the Code of Virginia.

§ 2. General.

These regulations are promulgated pursuant to the authority set forth in § 55-200.1 of the Code of Virginia which requires the State Treasurer to adopt any necessary rules and regulations in accordance with the Administrative Process Act to carry out the provisions of the Escheat Generally Statutes, Chapter 10 (§ 55-168 et seq.) of Title 55 of the Code of Virginia.

§ 3. Effective date.

These regulations shall be effective on and after July 1, 1992.

§ 4. Annual reporting requirement for local government treasurers.

An Annual Escheat Report shall be [~~remitted~~ submitted] by each local government treasurer, director of finance, or other designated local government official to the appointed escheator for that locality and to the agency by May 31 of each year for the calendar year just ended. This report is required even if there are no real property parcels to be reported. The report shall be prepared on the appropriate form, or in an approved format, and shall be submitted on either hard copy or an acceptable diskette in a file layout and format approved by the agency. The report shall be certified as to its accuracy by the commissioner of revenue or designated local official prior to the May 31 submission date.

[The local government treasurer, director of finance, or other designated local government official shall include in the Annual Escheat Report all real properties: (i) of which no one is known by that official to be the owner, or (ii) which appear to be abandoned under any of the following criteria: (a) property which the owner has communicated in writing to the designated local government official an intent to abandon; (b) property on which no property taxes have been paid for 10 years of more, unless the property is actually occupied by the owner, in which case a proceeding pursuant to § 58.1-3965 of the Code of Virginia is apropriate; (c) property on which the local government has had to abate a nuisance (e.g., cutting of weeds, boarding-up or razing of abandoned structure, etc.) and on which no property taxes have been paid for five or more years; and (d) property of which other evidence of abandonment may be relevant, including instances where heirs of an owner may be known, but none have taken an active role in the management or maintenance of the property, resulting in its deterioration.]

§ 5. Annual reporting requirements for escheators.

Escheators shall be required to file a report with the agency by [~~May~~ March] 1 of each year, for the calendar year just ended, summarizing escheat activity for that period. The required report shall include, but not be limited to, (i) information about any litigation occurring during the period and the status of such litigation, (ii) the status of any collection proceedings, (iii) the status of any real estate parcels removed from the escheat process subsequent to an inquest, (iv) the status of any other real estate parcels under the escheator's control, and (v) any other information which should be brought to the agency's attention that the escheator deems to be relevant to the escheat process. The escheator shall provide, upon written request from the agency, any additional data relating to this report within 30 days of such request.

§ 6. Required bond for escheators.

Each escheator shall give a "Personal Recognizance Bond" before the circuit court of the county or the city for which the escheator is appointed in the amount of $3,000 within 60 days of confirmation of the appointment and provide the agency with a copy of the bond. This bond shall remain in force as long as the escheator shall continue in office until removed or until a successor is duly appointed and qualified.

§ 7. Escheator's responsibility for collection of sale proceeds and remittance to State Treasurer.

The escheator shall be responsible for the collection of all moneys during the escheat process. Any and all moneys collected during the escheat process shall be deposited into the bank account of the escheator no later than the next banking day following the collection date. A check for the full amount collected shall be drawn on this account and made payable to the Treasurer of Virginia no later than 10 banking days following the deposit date. The escheator shall submit the check and complete columns 5, 6, 7 and 8 of the Annual Escheat Report Form received from the local treasurer or submit other supporting documentation for funds collected other than sale proceeds.

The escheator shall be responsible for the collection of any checks relative to the escheat process returned by the bank to the escheator's bank account for insufficient funds or any other reason which makes a check uncollectible. The escheator shall institute procedures for collection of these moneys immediately upon notification from the bank that a check has been returned uncollected. The procedures shall include, but not be limited to, a written notice to the maker of the returned check advising the maker that payment, with certified funds or cash, be made within five business days of the correspondence date. In regard to a sale transaction, the notice shall state that failure to comply may result in (i) the forfeiture of any deposit and the resale of escheated property pursuant to § 55-187 of the Code of Virginia, (ii) a suit to enforce specific performance of the sale agreement, (iii) resale of the property and suit for any damages resulting from [~~nonperformance~~ default] by the purchaser, [or] (iv) any other remedy at law or in equity available to a seller against a defaulting purchaser or real estate.

§ 8. Defaulting purchasers.

If a sale of escheated property is [~~rescinded~~ not consummated for any reason constituting a default by the purchaser] pursuant to § 55-187, the escheator shall notify the purchaser in writing that [~~(i) due to~~] the purchaser's [~~nonperformance, the property will be offered for sale~~ default may result in (i) the forfeiture of any deposit and the resale of the escheated property] at the next sale of escheated property for that locality, (ii) [~~the purchaser may be held liable for any deficiency which arises~~ a suit to enforce specific performance of the sale agreement, (iii) resale of the property and a suit for any

damages resulting] from the subsequent sale at a lesser purchase price, [~~(iii)~~ (iv) any other remedy at law or in equity available to a seller against a defaulting purchaser of real estate, and (v)] cash or a certified check [~~will be~~ being] required from the purchaser from any future transaction involving the purchase of escheated property [; ~~and (iv)~~ . The notification shall also inform] the purchaser [~~has a~~ of the] right to have an administrative review of actions taken by the escheator or the agency. Before an escheator may bring a suit against a defaulting purchaser, express authority to do so in each case shall be obtained from the Office of the Attorney General of the Commonwealth of Virginia and approval of anticipated expenses of litigation shall be obtained from the agency.

§ 9. Required written disclosures to be made by the escheator at the escheat auction.

The escheator shall provide written information to any and all individuals who register as a bidder for an escheat sale that the grant for the escheated property will be issued in accordance with § 55-186.1 of the Code of Virginia and that this statutory form of grant contains no warranty of title. In addition, the written information shall instruct any and all bidders seeking a recovery of proceeds from a sale of escheated property that the recovery of proceeds of each sale from the Commonwealth, less the expenses of sale and the escheator's fee, may be obtained if the buyer, pursuant to § 55-200 of the Code of Virginia, submits satisfactory evidence to the State Treasurer within 120 days of the sale that the escheated property does not exist or was improperly escheated.

§ 10. Commission basis for the escheator and the auctioneer.

The commissions paid to the escheator [(10%)] and the auctioneer [(5.0%)] are determined based on the proceeds collected from the sales of escheated property. If a partial payment is collected and the purchaser fails to complete the sales transaction, the purchaser forfeits the partial payment to the State Treasurer and the commissions paid shall be based on the partial payment only. The commissions base does not include recording fees. [Reimbursable expenses of the escheator and auctioneer are in addition to the commissions paid.]

§ 11. Reimbursable expenses and required documents of the auctioneer.

The auctioneer shall submit an expense report with supporting documentation of the State Treasurer within 30 days of the auction to ensure proper reimbursement of the auction expenses pursuant to § 55-186. Reimbursable expenses shall include: advertisements, postage, payroll, and any other expenses directly related to the auction, but in no case shall the expense reimbursement exceed 5.0% of the proceeds collected. Proceeds do not include recording fees.

§ 12. Fees charged for requests under the Freedom of Information Act.

Fees shall be computed on all requests for information under the Freedom of Information Act, Chapter 21 (§ 2.1-340 et seq.) of Title 2.1 of the Code of Virginia, related to the escheat process. The fee assessed shall be determined based on the actual time of the employee performing the duties necessary to comply with the request and other costs incurred. Other costs include copies, postage, and any other cost directly associated with providing the requested information.

If there is an amount due the agency and it is in excess of 30 days past due, current and future requests for information will be withheld until the outstanding amount is paid to the agency. Continued failure to pay fees when due may result in the agency requesting payment in advance.

INSTRUCTIONS FOR PREPARING ANNUAL ESCHEAT REPORT

The local treasurers must file this report by May 31 pursuant to Section 55-171 of the *Code of Virginia*. It is to be completed by the local treasurers following the criteria below:

1. The property owner died intestate without leaving any known heirs.
2. No person is known by the local treasurer, commissioner of revenue or appointed tax assessor to be entitled to the property.
3. Property which appears abandoned.

NOTE: Non-payment of taxes or special assessments (for a period of ten (10) years) do not necessarily mean the property is escheatable, but may be used to support the above criteria.

The commissioner of revenue or person assigned his duties must certify the properties listed on the annual report as well as the local treasurers.

* * * * * * * * * * REPORT FORMAT * * * * * * * * * *

(1) **TYPE OF REPORT** (To be completed by local treasurer): If there are no parcels to report, check the "negative" field. If there are parcels to report, check the positive field and indicate the number of parcels reported.

(2) **TAX MAP NUMBER** (To be completed by local treasurer): If tax map number is available, please list. If not, indicate "NOT AVAILABLE".

(3) **LAST KNOWN OWNER & MAILING ADDRESS** (To be completed by local treasurer): List the last known owner as indicated on the records of the locality. If there was no last known owner, indicate "UNKNOWN", "NOT AVAILABLE", or other description as applicable. If the mailing or street address is available please list. If not available indicate "ADDRESS NOT AVAILABLE".

(4) **PROPERTY DESCRIPTION** (To be completed by local treasurer): List the legal description as recorded on the locality's records (Example: Lot 2, Block A, XYZ Subdivision, 2.4 Acres).

By May 31, the local treasurer must forward this report to the Escheator of the locality and submit a copy to the Department of the Treasury, Division of Unclaimed Property.

(5) **STATUS CODE** (To be completed by Escheator): Use the following codes to indicate the status of a parcel through the entire escheat process:

A - Removed prior to inquest
B - Removed at inquest
C - Removed after inquest, but prior to sale
D - Removed at the time of sale
E - Defaulted purchaser, carry over to next sale (requires approval pursuant to Section 55-187)
F - Approved extension, carry over to next sale

(6) **SALE PRICE** (To be completed by Escheator): Indicate the highest bid at the auction. If different from amount collected attach an explanation to the report.

(7) **RECORDING FEE** (To be completed by Escheator): Indicate the dollar amount collected from purchaser. Amount of recording fee pursuant to Section 55-186 should be verified prior to sale.

(8) **PURCHASER'S NAME & ADDRESS** (To be completed by Escheator): Indicate the purchaser's name as it should be recorded on the grant. Please indicate entitlement if appropriate. Use the list below as a guide.

JT - Joint tenants
JTROS - Joint tenants with rights of survivorship
TIC - Tenants in common
TEROS - Husband and wife, as tenants by the entireties with the right of survivorship
SSEE - Sole separate equitable estate
OTH - Specify under the purchasers name and address for those not listed above

* *

The escheator will update the report with any changes occurring prior to the sale and forward an updated copy to the Division of Unclaimed Property with supporting documentation whenever changes occur. Once the properties are sold, the escheator will complete the report and forward the original to the Division of Unclaimed Property.

REMEMBER!!! All receipts from the escheat sale, including the recording fee, must be submitted to the Division of Unclaimed Property within ten (10) days of the sale. The final report must be received by the Division within 30 days of the sale.

Reports must be submitted on this form or in the same format.

If you have any questions or need further assistance, please contact the Division of Unclaimed Property, Escheat Officer at (804) 225-2393 or 1-800-468-1088.

ANNUAL ESCHEAT REPORT
LIST OF REAL PROPERTY PRESUMED ABANDONED
(CODE OF VIRGINIA SECTION 55-168 THROUGH 55-200.1)

PAGE ___ OF ___

LOCALITY	FED. ID#
TREASURER'S NAME AND ADDRESS	TREASURER'S SIGNATURE
	COMMISSIONER OF REVENUE'S SIGNATURE
ESCHEATOR'S NAME	REPORT YEAR 19___

TYPE OF REPORT (*)
___ NEGATIVE
___ POSITIVE
___ # OF PARCELS

COMMONWEALTH OF VIRGINIA
Department of the Treasury
Division of Unclaimed Property
P. O. Box 3-R
Richmond, Virginia 23207

MUST BE TYPED

TAX MAP NUMBER (2)	LAST KNOWN OWNER AND MAILING ADDRESS (3)	PROPERTY DESCRIPTION (4)	STATUS CODE (5)	SALE PRICE (6)	RECORDING FEE (7)	PURCHASER'S NAME AND ADDRESS (SPECIFY ENTITLEMENT IF NECESSARY SEE INSTRUCTIONS) (8)
TOTALS BROUGHT FORWARD FROM PREVIOUS PAGE				$	$	
ESH-1 3/91	SUBMIT YOUR REPORT BY MAY 31 OF REPORT YEAR			$	$	TOTALS CARRIED FORWARD TO NEXT PAGE

STATE WATER CONTROL BOARD

Title of Regulation: **VR 680-21-00. Water Quality Standards.**
VR 680-21-07.1. Special Standards and Requirements.
VR 680-21-08.15. Tennessee and Big Sandy River Basin, Clinch River Subbasin.

Statutory Authority: § 62.1-4415(3a) of the Code of Virginia.

Effective Date: July 1, 1992.

Background:

Water quality standards and criteria consist of narrative statements that describe water quality requirements in general terms and numerical limits for specific physical, chemical and biological characteristics of water. These statements and limits describe water quality necessary for reasonable, beneficial water uses such as swimming, propagation and growth of aquatic life, and domestic water supply.

Summary:

The purpose of the regulatory action is to establish a site specific modification to the numerical water quality criteria for copper in the Clinch River between Carbo and St. Paul by amending VR 680-21-07.1 and VR 680-21-08.15. Based on studies conducted by Appalachian Power Company (APCo), the amendments establish an instream acute standard for copper of 19.5 ug/l and a chronic standard for copper of 12.4 ug/l for the impacted 12.6 miles of the Clinch River. The special standard is designed to provide protection to endangered species of freshwater mussels. APCo's hydroelectric power facility at Carbo will be required to upgrade the existing treatment facilities for metals removal, but the company's already planned treatment upgrade for compliance with § 304(1) of the Clean Water Act requirements should enable them to meet the special instream copper criteria without any additional costs.

VR 680-21-07.1. Special Standards and Requirements.

The special standards are shown in small letters to correspond to lettering in the basin tables. The special standards are as follows:

y. Clinch River from the confluence of Dumps Creek at river mile 268 at Carbo downstream to river mile 255.4. The special water quality standard for copper (measured as total recoverable) in this section of the Clinch River is 12.4 ug/l for protection from chronic effects and 19.5 ug/l for protection from acute effects. This site specific standard is needed to provide protection to several endangered species of freshwater mussels.

VR 680-21-08.15. Tennessee and Big Sandy River Basin - Clinch River Subbasin.

SEC.	SECTION DESCRIPTION	CLASS	SP.STDS.
21	*Reserved for public water supply.*		
2m	*Clinch River from the confluence of Dumps Creek at river mile 268 at Carbo downstream to river mile 255.4 at St. Paul.*	*IV*	*y*

DEPARTMENT OF SOCIAL SERVICES (BOARD OF)

Title of Regulation: **VR 615-70-17.14. Child Support Enforcement Program.**

Statutory Authority: § 63.1-25 of the Code of Virginia.

Effective Dates: May 5, 1992, through May 4, 1993.

Preamble:

The State Board of Social Services at their January 15th meeting recommended that the department issue as an emergency regulation a proposed amendment which was submitted to them for their approval. They recommended that this amendment be submitted as an emergency because it rectifies an inequity to children for whom the department is providing child support services and because it could result in a reduction in the Aid to Dependent Children caseload.

The emergency regulation is numbered with a ".14" as this amendment is the 14th amendment to the Child Support Enforcement Regulation numbered 615-70-17. Earlier amendments were not numbered in this manner, but subsequent amendments to the regulation will be so numbered.

Summary:

The emergency amendment to the child support regulation would allow the department to use data on the cost of raising a child in the urban south published by the United States Department of Agriculture to establish an obligation when the absent parent does not provide the financial information needed to establish an obligation based on the child support guideline.

VR 615-70-17.14. Child Support Enforcement Program.

PART I.
DEFINITIONS.

§ 1.1. Definitions.

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

"ADC" means Aid to Dependent Children which is established under Title IV-A of the Social Security Act. This is a category of financial assistance paid on behalf of children who are deprived of one or both of their parents by reason of death, disability, or continued absence (including desertion) from the home. established under Title IV-E of the Social Security Act. This is a category of financial assistance paid on behalf of children who otherwise meet the eligibility criteria for ADC and who are in the custody of the local social service agencies.

"ADC/FC" means Aid to Dependent Children/Foster Care which is established under Title IV-E of the Social Security Act. This is a category of financial assistance paid on behalf of children who otherwise meet the eligibility criteria for ADC and who are in the custody of the local social service agencies.

"Administrative" means noncourt ordered, legally enforceable actions the department may take to establish or enforce a child support obligation.

"Appeal" means a request for a review of an action taken by the division.

"Application" means a written document requesting child support enforcement services which the department provides to the individual or agency applying for services and which is signed by the custodial parent or agency representative.

"Assignment" means any assignment of rights to support or any assignment of rights to medical support and to payments for medical care from any third party.

"Bad check" means a check not honored by the bank on which it is drawn.

"Custodial parent" means (i) the natural or adoptive parent with whom the child resides, (ii) a step-parent or other person who has legal custody of the child and with whom the child resides, or (iii) a social service agency which has legal custody of a child in foster care.

"Debt" means the total unpaid support obligation established by court order, administrative order, or payment of public assistance which is owed by an absent responsible parent to either the custodial parent or to the Commonwealth.

"Default obligation" means an obligation based on factors other than the absent parent's ability to pay because of the absent parent's failure to provide financial information.

"Delinquent" means an unpaid child support obligation.

"Department" means the Virginia Department of Social Services.

"Disregard payment" means a payment made to an ADC recipient in an amount up to $50. The payment is made from the current child support collected on the individual's behalf.

"District office" means a local office of the Division of Child Support Enforcement responsible for the operation of the Child Support Enforcement Program.

"Division" means the Division of Child Support Enforcement of the Virginia Department of Social Services.

"Enforcement" means ensuring the payment of child support through the use of administrative or judicial means.

"Erroneous payment" means a payment sent to the custodial parent for which no funds were received by the department to be paid to that client.

"Financial statement" means a sworn document from the custodial parent and absent responsible parent showing their financial situation.

"Foreclosure" means a judicial procedure to enforce debts involving forced judicial sale of the real property of a debtor.

"Health care coverage" means any plan providing hospital, medical, or surgical care coverage for dependent children provided such coverage is available and can be obtained by an absent responsible parent at a reasonable cost.

"Hearings officer" means a disinterested person designated by the department to hold appeal hearings and render appeal decisions.

"IV-D agency" means a governmental entity administering the child support program under Title IV-D of the Social Security Act. In Virginia the IV-D agency is the Division of Child Support Enforcement.

"Judicial" means an action initiated through a court.

"Location only services" means that certain entities such as courts and other state child support enforcement agencies can receive only locate services from the department.

"Local social service agency" means one of Virginia's locally administered social service or welfare departments which operate the ADC and ADC/FC programs and other programs offered by the department.

"Location" means obtaining information which is sufficient and necessary to take action on a child support case including information concerning (i) the physical whereabouts of the absent parent or his employer, or (ii) other sources of income or assets, as appropriate.

"Medicaid only" means a category of public assistance whereby a family receives Medicaid but is not eligible for or receiving ADC.

"Mistake of fact" means an error in the identity of the absent responsible parent or in the amount of child support owed.

"Obligation" means the amount and frequency of payments which the absent responsible parent is legally bound to pay.

"Pendency of an appeal" means the period of time after an administrative appeal has been made and before the final disposition.

"Public assistance" means payments for ADC, or ADC/FC, or Medicaid-only.

"Putative father" means an alleged father; a person named as the father of a child born out-of-wedlock but whose paternity has not been established.

"Reasonable cost" means, as it pertains to health care coverage, available through employers, unions, or other groups without regard to service delivery mechanism.

"Recipient" means a person receiving public assistance.

"Responsible parent" means a person required under law to support a dependent child or the child's caretaker.

"Service" or "service of process" means the delivery to or leaving of, in a manner prescribed by state statute, an administrative or court order giving the absent responsible parent reasonable notice of the action being taken against him and affording the person an opportunity to be heard regarding the matter.

"Summary of facts" means a written statement of facts outlining the actions taken by the department on a case which has been appealed.

"Supplemental Security Income" means a program administered by the federal government which guarantees a minimum income to persons who meet the requirement of aged, blind, or disabled.

PART II.
GENERAL INFORMATION.

Article 1.
Services.

§ 2.1. Services provided.

A. Child support enforcement services shall be provided as a group to ADC, ADC/FC, and non-ADC clients. Courts and other state IV-D agencies may apply for location-only services. Medicaid only clients shall be provided services to establish or enforce medical support and may, at their request, receive full services.

B. Child support enforcement services shall include the following services which may involve administrative or court action:

1. Location of absent responsible parents, their employers, or their sources of income;

2. Establishment of paternity;

3. Establishment or modification of child support

obligations, including the responsibility to provide health care coverage;

4. Enforcement of child support obligations, both administratively and judicially determined; and

5. Collection and disbursement of child support payments, regardless of whether the obligation is legally established.

§ 2.2. Eligibility for services.

A. Individuals residing in Virginia who receive ADC, ADC/FC, or Medicaid only assistance are automatically eligible for child support services.

1. ADC and ADC/FC applicants and recipients must accept child support services as a condition of eligibility for public assistance unless the local social service agency determines that good cause exists for not accepting these services.

2. Medicaid only applicants and recipients must accept medical support and paternity establishment services as a condition of eligibility for Medicaid unless the local social services agency determines that good cause exists for not accepting these services.

3. The department shall suspend action on a child support case in which the local social service agency has determined that good cause exists for not cooperating with the department in its pursuit of child support.

4. The department shall continue to provide child support services to a custodial parent when the ADC, ADC/FC, or Medicaid only case closes.

a. The department shall provide these services without requiring a formal application.

b. The department shall continue to provide these services until the custodial parent states in writing that the services are no longer wanted unless the closure of the child support case is contrary to state or federal law.

B. Individuals residing in Virginia or having a legal residence in Virginia who do not receive ADC, ADC/FC, or Medicaid only assistance must make an application for child support services as a condition of eligibility for those services with the exception that an application is not required for cases transferred from the courts to the department on or after October 1, 1985. For such cases the payee shall be deemed as having executed an authorization to seek or enforce a support obligation with the department unless the payee specifically indicates that the department's services are not desired.

1. The child for whom child support is being requested must be under 18 years of age, unless:

a. There is a court order specifying that support continue until a later age, or

b. The child is handicapped, or

c. The services being requested are for a child support obligation which existed prior to the child's 18th birthday.

2. If the child for whom support is being sought is under 18 years of age, the applicant must be the parent or legal guardian of the child and the child must reside with the applicant.

C. Individuals residing outside of Virginia shall be eligible for child support services upon a request for services from the IV-D agency in the state in which they reside.

D. Courts and other state IV-D agencies are eligible for location only services.

Article 2.
Department as Payee.

§ 2.3. Assignment of rights.

A. Assignment of child support rights to the Commonwealth is automatic by operation of law with receipt of ADC and ADC/FC assistance and continues after the public assistance case closes unless the client requests in writing that the services be terminated.

B. Assignment of medical support rights to the Commonwealth is automatic by operation of law with receipt of Medicaid only assistance and continues after the public assistance case closes unless the client requests in writing that the service be terminated.

§ 2.4. Authorization to seek or enforce a child support obligation.

Persons receiving child support services shall give the department written authorization to seek or enforce support on behalf of the child or spouse and child.

§ 2.5. Special conditions regarding receipt of ADC or ADC/FC.

A. Receipt of ADC or ADC/FC assistance creates a debt to the Commonwealth.

B. If a debt is owed to the Commonwealth due to the receipt of ADC or ADC/FC assistance, the department shall apply amounts collected for past due child support toward this debt unless the court order stipulates otherwise.

C. Money received from tax intercept shall be applied, in total, toward the ADC or ADC/FC debt.

Article 3.
Application and Case Assessment and Prioritization.

§ 2.6. Application fees.

The application fee for child support services is $1.00 for nonpublic assistance clients. The department shall pay this fee on behalf of such applicants for child support enforcement services.

§ 2.7. Application process.

A. The department shall make applications accessible to the public and shall include with each application information describing child support enforcement services, the custodial parent's rights and responsibilities, the absent responsible parent's rights, and payment distribution policies.

1. The department shall provide an application on the day an individual requests the application when the request is made in person.

2. The department shall send applications within five working days of the date a written or telephone request for an application is received.

B. The department shall provide ADC, ADC/FC, and Medicaid-only recipients with the above information, the rights and responsibilities of custodial parents, the absent responsible parent's rights and general distribution policies within five working days of receiving the referral from a local social service agency.

C. The department shall, within two calendar days of the date of application from a nonpublic assistance recipient or the date a referral of a public assistance recipient is received, establish a case record, and within 20 calendar days, obtain the information needed to locate the absent responsible parent, initiate verification of information, if appropriate, and gather all relevant facts and documents.

§ 2.8. Case assessment and priorization.

A. Case assessment.

The department shall (i) assess the case information to determine if sufficient information to establish or enforce a child support obligation is available and verified and (ii) attempt to obtain additional case information if the information is not sufficient and (iii) verify case information which is not verified.

B. Case prioritization.

1. The department shall give priority to cases which contain any of the following on the absent responsible parent or putative father:

a. Verified, current, residential address; or

b. Current employer; or

c. Last known residential address or last known employer if the information is less than three years old; or

d. Social security number and date of birth.

2. The department shall give low priority but shall review periodically cases in which:

a. There is not adequate identifying or other information to meet requirements for submittal for location, or

b. The absent responsible parent receives supplemental security income or public assistance.

§ 2.9. Service of process.

Service is necessary when child support obligations are established either administratively or through court action and, in some instances, when actions to enforce the obligation are taken.

A. The methods of service of process required by law vary with the action being taken and include individual personal service, substituted service, posted service, certified mail, and regular mail.

B. The department shall use diligent efforts to serve process. Diligent efforts to serve process shall include:

1. When the method of service of process used to notify an absent parent of an administrative action is not successful and the address of the absent responsible parent is known and verified, the department shall exhaust every method of service allowed by law.

2. When the method of service of process used to notify an absent parent of court action is not successful and the address of the absent parent is known and verified, the department shall provide the sheriff or process server with additional information about the absent parent's address.

3. When the method of service of process is not successful after the department has exhausted all methods of service allowed or has provided the sheriff or process server with an additional information, the department shall repeat its attempts to serve process at least quarterly.

§ 2.10. Costs associated with the provision of child support services.

A. The department may not require custodial parents to pay the costs associated with the provision of child support services.

B. The putative father shall pay the costs associated with the determination of paternity if he is ordered by a court to pay these costs.

PART III.
LOCATION.

§ 3.1. The department shall provide location services (i) whenever the location of absent responsible parents or their employers is needed in order to establish or enforce a child support obligation and (ii) when there is sufficient identifying information available to the department to access location sources.

§ 3.2. Location sources.

Whenever location services are provided, the department shall access all necessary locate sources. Locate sources include but are not limited to:

1. Local public and private sources.

2. State Parent Locator Services.

3. Electronic Parent Locator Network.

4. Central Interstate Registry.

5. Federal Parent Locator Service.

6. Parents, friends, and other personal sources.

§ 3.3. Location time requirements.

A. The department shall access all appropriate location sources within 75 calendar days of receipt of the application for child support services or the referral of a public assistance recipient if the department determines that such services are needed and quarterly thereafter if the location attempts are unsuccessful.

B. The department shall review at least quarterly those cases in which previous attempts to locate absent responsible parents or sources of income or assets have failed, but adequate identifying and other information exists to meet requirements for submittal for location.

C. The department shall provide location services immediately if new information is received which may aid in location.

D. When the custodial parent resides in Virginia, the department shall utilize the Federal Parent Locator Service at least annually when other location attempts have failed.

E. When another state requests location services from the department, the department shall follow the time requirements described in the Code of Federal Regulations, Title 45, part 303, § 303.7.

PART IV.
ESTABLISHING CHILD SUPPORT OBLIGATIONS.

Article 1.
Paternity Establishment.

§ 4.1. Establishing paternity.

In order for the department to establish a child support obligation and to enforce and collect child support payments from a putative father, the father must be determined to be legally responsible for the support of the child. In situations in which a putative father has not been legally determined to be the father of the child, paternity must be established before a child support obligation can be administratively ordered or court ordered.

1. The department shall obtain a sworn statement(s) from the custodial parent acknowledging the paternity of the child or children for whom child support is sought.

2. Based on this sworn statement, the department shall attempt to locate the putative father, if necessary, according to the locate time requirements described in Part III above.

3. Once the putative father is located, the department shall contact him to determine if he is willing to sign a sworn statement voluntarily acknowledging paternity or to voluntarily submit to blood testing to determine paternity.

a. The department shall advise the putative father verbally and in writing of his rights and responsibilities regarding child support prior to obtaining a sworn statement of paternity.

b. A putative father who signs a sworn statement of paternity along with an acknowledgement from the mother or who, through genetic blood testing, is affirmed by at least a 98% probability to be the father of the child is responsible for the financial support of the child or children.

4. When the putative father does not sign a sworn statement of paternity or does not voluntarily submit to blood testing or the blood test shows less than a 98% probability of paternity, the department shall petition the court for a paternity determination when there is sufficient evidence to do so.

5. Within 90 calendar days of locating the putative father, the department shall:

a. Obtain a sworn acknowledgement of paternity or arrange for voluntary blood testing, or

b. File a petition with the court for paternity establishment.

6. In any case where more than one putative father has been identified, the department shall pursue paternity for all putative fathers.

7. The department shall track all cases in which paternity must be established to assure that, in all cases where the putative father is located, paternity is established or the putative father excluded within one year of the child reaching six months of age or within one year of petitioning the court for paternity, whichever occurs later.

§ 4.2. Establishing paternity in interstate cases.

The department shall establish, if possible, the paternity of children who do not reside in Virginia when the putative father resides in Virginia and a request for such services is received from another state IV-D agency.

Article 2.
Administrative Support Orders.

§ 4.3. Administrative establishment of a child support obligation.

The department has statutory authority to establish child support obligations through noncourt ordered legally enforceable administrative means. These administrative obligations have the same force and effect as a support obligation established by the court.

A. The amount of child support that is owed and the frequency with which it is paid must be established before the payment of child support can be enforced.

B. The administrative order shall be called the Administrative Support Order.

C. The department shall use administrative rather than judicial means to establish the child support obligation whenever possible.

D. The department shall use administrative means to establish a temporary child support obligation when judicial determinations of support are pending due to custody and visitation issues.

E. Within 90 calendar days of locating the absent responsible parent, or of establishing paternity the department shall attempt to either ensure that a child support obligation is established or shall diligently attempt to complete the service of process necessary for an obligation to be ordered.

F. When a court dismisses a petition for a support order without prejudice or an administrative hearings officer overrules an administrative support action, the department shall examine the reasons for the dismissal or overruling and determine when or if it would be appropriate to seek an order in the future.

G. The child support obligation is established when an Administrative Support Order has been served and the 10-day appeal period for the administrative order has elapsed.

H. The department shall modify the obligation when new information is received necessitating a change.

I. The department shall modify the amount of the obligation for future child support payments only.

§ 4.4. Determining the amount of the child support obligation.

A. The obligation shall include:

1. Frequency with which the current amount owed is to be paid,

2. Current amount owed,

3. Public assistance debt, if any, and

4. Unpaid past due child support, if any.

B. Financial statements.

1. The department shall use financial statements obtained from the absent responsible parent and the custodial parent to determine the amount of the child support obligation. *When financial statements are not provided, the department may use financial information obtained from other sources such as, but not limited to, the Virginia Employment Commission.*

2. The absent responsible parent and custodial parent shall complete financial statements upon demand by the department and annually thereafter. Such responsible parties shall certify under penalty of perjury the correctness of the statement.

3. If the custodial parent is a recipient of public assistance, the department shall use the information obtained through the ADC or ADC/FC eligibility process to meet the financial statement requirement.

4. The department shall define the type of financial information which shall be required based on § 63.1-274.5 of the Code of Virginia which is incorporated by reference.

5. A custodial parent who is not a responsible parent of the child for whom child support is being sought shall not be required to complete a financial statement.

6. The department shall obtain financial statements from both absent responsible parents when the custodial parent is not a responsible parent of the child.

~~C. When an absent parent is responsible for the support of children receiving ADC or ADC/FC assistance, the department shall initially base the amount of the obligation on the amount of ADC or ADC/FC paid on behalf of the responsible parent's dependents.~~

~~1. The department shall change the proposed obligation amount and base it on the child support scale if the absent responsible parent provides financial information during the pendency of an administrative appeal.~~

~~2. If the department receives financial information after the obligation is established, the department shall modify the Administrative Support Order prospectively and shall base the future obligation amount on the child support scale.~~

C. Default obligations.

~~D.~~ When the absent parent ~~is responsible for the support of children not receiving ADC or ADC/FC and provides~~ does not provide a financial statement ~~the department shall base the amount of the obligation on the child support scale.~~ *and financial information cannot be obtained from other sources*

~~1. If the responsible parent does not provide a financial statement~~ and there is no court order and no previously issued administrative order, the department shall issue a default Administrative Support Order.

1. The default administrative order shall be based on the USDA estimated family expenditures on raising a child in the urban south in combination with the Virginia adjusted gross income and shall be revised yearly.

2. ~~The~~ *In situations where an obligation is not being established to assess a current obligation, but is assessing past public assistance debt only, the* default administrative order shall be based on the amount of public assistance ~~that would be~~ paid on behalf of the absent responsible parent's dependents ~~if they were eligible for ADC assistance~~ .

3. Within 30 days of establishing a default administrative obligation, the department shall petition the court for a modification of the obligation based on the absent parent's ability to pay.

~~E.~~ *D.* The department shall determine the amount to be paid monthly toward a child support debt when the obligation is administratively ordered and when a court ordered obligation for support does not specify the amount to be paid toward the debt. The monthly payment for arrears will be $65 or 25% of the current obligation, whichever is greater, and shall not exceed the amount allowed under the Consumer Credit Protection Act.

§ 4.5. Service of the administrative support order.

The department must legally serve the Administrative Support Order on the absent responsible parent or receive a waiver of service from the responsible parent in order to have an established obligation.

§ 4.6. Health care coverage.

A. The department shall have the authority to issue orders requiring provisions of health care coverage for the dependent children of absent responsible parents if the coverage is available at reasonable cost as defined in § 63.1-250.1 of the Code of Virginia.

B. The absent responsible parent shall provide information regarding health care coverage for his dependent children, and his spouse or former spouse if applicable, upon request from the department.

C. The absent responsible parent shall provide health care coverage for the child or children if medical insurance is available through his employment. The department may enter an administrative order or seek a judicial order requiring the absent responsible parent's employer to enroll the dependent children in a group health insurance plan or other similar plan providing health care services or coverage offered by the employer as provided in § 20-79.3 of the Code of Virginia.

§ 4.7. Child support scale.

A. The department is required to use the Schedule of Monthly Basic Child Support Obligations and procedures in § 20-108.2 of the Code of Virginia in calculating the amount of administrative child support obligations. This section of the Code is incorporated by reference.

B. The department shall call this schedule the child support scale.

C. The department shall use the scale in establishing Administrative Support Orders except ~~in the two situations identified~~ *when a default obligation is established as is defined* in § 4.4 C ~~and D~~ 1 .

D. The total child support obligation will be divided between both parents in the same proportion as their individual gross incomes bear to their combined gross income.

E. The department shall consider the following factors in calculating the combined gross income:

1. The absent responsible parent and custodial parent's gross monthly income from all sources with the exception noted in subsection F of this section,

2. The number of children for whom the absent responsible parent and custodial parent share joint legal responsibility,

3. Extraordinary medical and dental expenses which

are defined in § 20-108.2 of the Code of Virginia, and

4. The custodial parent's work related child care expenses.

F. The department may not include benefits from public assistance programs as defined in § 63.1-87, Supplemental Security Income, or child support received in calculating the combined gross income.

§ 4.8. Periodic reviews of the child support obligation.

The amount of the child support obligation is based on the financial situation of both parents. The department or the courts, depending on who issued the order, may modify the amount of the obligation if the parents' situation changes. Either the department or either parent may initiate a review of the amount of the child support obligation.

A. The department shall initiate a review of each child support obligation as required by federal regulations.

B. Either parent may initiate a review of the child support obligation by providing documentation of a change in circumstances potentially affecting the child support obligation.

C. The department shall modify an administrative obligation when the results of the review indicate a change in the gross income of either parent which is a difference of at least 10% in either parent's gross monthly income or a change in the monthly obligation of at least $25.

D. The department shall petition to modify a court ordered obligation based on criteria established by the court.

PART V.
ENFORCING CHILD SUPPORT OBLIGATIONS.

Article 1.
General.

§ 5.1. Enforcement rules.

A. The department shall, whenever possible, administratively enforce compliance with established child support orders including both administrative and court orders.

B. The department shall enforce child support obligations at the time the Administrative Support Order is initially entered through the use of one of the following methods of wage withholdings:

1. Immediate withholding of earnings

2. Voluntary assignment of earnings

C. The department shall enforce child support obligations when the obligation becomes delinquent through the use of one or more of the following administrative enforcement remedies:

1. Mandatory withholding of earnings

2. Liens

3. Orders to withhold and deliver

4. Foreclosure

5. Distraint, seizure, and sale

6. Unemployment compensation benefits intercept

7. Bonds, securities, and guarantees

8. Tax intercept

9. Internal Revenue Service full collection service

10. Credit bureau reporting

11. Enforcement remedies for federal employees.

D. The department shall attempt to enforce current and delinquent child support payments through administrative means before petitioning the court for enforcement action unless it determines that court action is more appropriate.

E. The department shall take any appropriate enforcement action, unless service of process is necessary, within no more than 30 calendar days of identifying a deliquency or of locating that absent responsible parent, whichever occurs later, except income withholding and federal and state income tax refund offset.

F. The department shall take appropriate enforcement action if service of process is necessary within 60 calendar days of identifying a delinquency or of locating the absent responsible parent, whichever occurs later.

G. The department shall take appropriate enforcement action within the above timeframes to enforce health care coverage.

H. When an enforcement action is unsuccessful, the department shall examine the reason(s) and determine when it would be appropriate to take an enforcement action in the future. The department shall take further enforcement action at a time and in a manner determined appropriate by department staff.

§ 5.2. Withholding of earnings rules.

A. The department may issue a withholding of earnings order against all earnings except those exempted from garnishment under federal and state law.

B. The amount of money withheld from earnings may not be more than the amount allowed under the Consumer Credit Protection Act. (§ 34-29 of the Code of Virginia)

C. The department must legally serve the wage withholding order on the absent responsible parent or receive a waiver of service from the individual.

D. The department shall modify the withholding of earnings order only if there is a change in the amount of the current support or past due debt.

E. The department shall release the withholding of earnings order only if one of the following occurs:

1. The current support obligation terminates and any past due debt is paid in full;

2. Only a past due debt is owed and it is paid in full;

3. The whereabouts of the child or child and caretaker become unknown;

4. Bankruptcy laws require release; or

5. A nonpublic assistance client no longer wants the services of the department.

Article 2.
Immediate and Voluntary Withholding of Earnings.

§ 5.3. General.

The Administrative Support Order shall include a requirement for immediate withholding of the child support obligation from the absent responsible parent's earnings. The custodial parent and absent responsible parent may choose a voluntary assignment of earnings as an alternate arrangement for payment of child support.

§ 5.4. Immediate withholding of earnings.

The Administrative Support Order shall include a requirement for immediate withholding of the child support obligation from the absent responsible parent's earning unless the absent responsible parent and the department, on behalf of the custodial parent, agree to an alternative arrangement, or good cause is shown.

§ 5.5. Voluntary withholding of earnings.

A. Voluntary withholding of earnings is also called voluntary assignment of earnings.

B. The custodial parent and absent responsible parent may choose a voluntary assignment of earnings at the time the obligation is established as an alternate to immediate withholding of earnings for payment of child support.

C. The department may initiate a voluntary assignment of earnings when it is the most expeditious means of enforcing a wage withholding.

D. The absent responsible parent may not choose a voluntary assignment of earnings as an alternative to mandatory withholding of earnings after enforcement action has been initiated.

Article 3.
Other Enforcement Remedies.

The department shall have the authority to administratively collect delinquent child support payments from absent responsible parents. These are called enforcement remedies.

§ 5.6. Mandatory withholding of earnings.

The department shall send a Mandatory Withholding of Earnings order to an employer requiring the deduction of the child support obligation from the absent responsible parent's earnings under the following circumstances:

1. When a payment is delinquent in an amount equal to or exceeding one month's child support obligation, or

2. When the custodial parent requests that withholding begin regardless of whether support payments are in arrears.

§ 5.7. Liens.

A. The department may file a lien on the real or personal property of the absent responsible parent when there is a support debt.

B. Upon receipt of a support order from a jurisdiction outside of Virginia, the department may immediately file a lien.

C. The lien of the department shall have the priority of a secured creditor.

D. The lien of the department shall be subordinate to the lien of any prior mortgagee.

E. The lien shall be released when the child support debt has been paid in full.

§ 5.8. Orders to withhold and deliver.

A. The department may use orders to withhold and deliver to collect assets such as bank accounts, trust funds, stocks, bonds, and other types of financial holdings when there is a support debt.

B. The department shall release the order to withhold when the order cannot be served on the absent responsible parent.

C. The department shall release the order to deliver when:

1. The debt on the order is paid, or

2. The absent responsible parent makes satisfactory alternate arrangements for paying the full amount of the debt.

§ 5.9. Distraint, seizure, and sale.

A. The department may use distraint, seizure, and sale against the real or personal property of an absent responsible parent when there is a support debt.

B. The director of the division shall give final approval for the use of distraint, seizure, and sale.

§ 5.10. Unemployment compensation benefits intercept.

A. The department may intercept unemployment compensation benefits when there is a support debt.

B. The department may, with the consent of the absent responsible parent, intercept unemployment compensation benefits when there is not a support debt.

C. The department may intercept unemployment compensation benefits paid by the Commonwealth to an absent responsible parent who lives out of state.

D. The department shall intercept the amount of benefits allowed by the Virginia Employment Commission.

§ 5.11. Bonds, securities, and guarantees.

The department shall use administrative bonds, securities, and guarantees as an enforcement action only if the amount of the delinquency exceeds $1,000 and

1. After all other enforcement actions fail, or

2. When no other enforcement actions are feasible.

§ 5.12. Tax intercept.

A. The department shall intercept state and federal income tax refunds and shall apply these moneys, in whole or in part, first to any debt to the Commonwealth and second to delinquent child support obligations.

B. The Virginia Department of Taxation prescribes rules for interception of state tax refunds and notification to the person whose tax refund is being intercepted.

1. The department may retain moneys up to the amount owed on the due date of the finalization notice from the department to the Virginia Department of Taxation.

2. The department may intercept state tax refunds when the delinquent amount equals at least $25.

3. The department may not disburse the intercepted taxes if the absent responsible parent has appealed the intercept action and the appeal is pending.

4. The department shall issue a refund to the absent responsible parent when one of the following occurs:

a. The intercept was made in error.

b. The absent responsible parent pays the delinquent amount in full after the Department of Taxation has been notified of the delinquency and before the tax refund is intercepted.

c. Either or both federal and state tax refunds are intercepted, the total amount intercepted is more than the amount of the delinquency at the time that notification of the tax intercept was sent to the Department of Taxation, and the absent responsible parent does not agree to allow the department to apply the excess funds to any delinquency that accrued after certification for tax intercept.

C. The Internal Revenue Service has prescribed rules regarding the interception of federal tax refunds. Part 45, §§ 302.60 and 303.72 of the Code of Federal Regulations are incorporated by reference in this regulation.

Article 4.
Federal Enforcement Remedies.

In addition to state administrative enforcement remedies, the department shall use federal enforcement remedies to enforce child support obligations.

§ 5.13. Internal Revenue Service full collection service.

A. The department may ask the Internal Revenue Service to collect delinquent child support payments when all reasonable efforts to collect past due child support payments have been made but have not been successful.

B. The department shall make this request through the federal Office of Child Support Enforcement.

§ 5.14. Enforcement remedies to be used against federal employees.

A. The department may apply its enforcement remedies against United States military and civilian active and retired personnel.

B. When enforcement under Virginia law is not possible, the department may use (i) Mandatory Military Allotments and (ii) Involuntary Child Support Allotments for Public Health Services Employees to enforce child support obligations of active military personnel and public health services employees.

1. For the purposes of these two enforcement actions, delinquency shall be defined as failure of the absent responsible parent to make child support payments equal to the amount due for two months.

2. The amount of money withheld from these wages shall be up to the amount allowed under the Consumer Credit Protection Act.

PART VI.
ADMINISTRATIVE APPEALS.

Actions to establish and enforce child support obligations administratively may be appealed according to the following rules.

§ 6.1. Validity of the appeal.

A. The department shall determine the validity of an appeal.

1. The appeal must be in writing.

2. The appeal must be received within 10 working days of service when personally delivered.

3. If mailed, the postmark must be no later than 10 working days from the date of service of the notice of proposed action.

B. The only exception to this shall be appeals of federal and state tax intercepts. The absent responsible parent shall have 30 days to appeal a tax intercept notice to the department.

§ 6.2. General rules.

A. The appeal shall be heard by a hearings officer.

1. The hearings officer shall hold the hearing in the district office where the custodial parent resides unless another location is requested by the absent responsible parent and it complies with § 63.1-267.1 of the Code of Virginia.

2. The absent responsible parent and the custodial parent may be represented at the hearing by legal counsel.

3. The absent responsible parent may withdraw the appeal at any time.

4. The hearings officer shall accept a request for a continuance from the absent responsible parent or the custodial parent if:

a. The request is made in writing at least five working days prior to the hearing, and

b. The request is for not more than a 10-day continuance.

B. The hearings officer shall notify the absent responsible parent and custodial parent of the date and time of the hearing and of the disposition of the hearing in accordance with § 63.1-267.1 of the Code of Virginia.

C. Prior to the hearing, the hearings officer shall send the absent responsible parent and the custodial parent a copy of the Summary of Facts prepared by the district office.

D. The hearings officer shall provide the absent responsible parent and the custodial parent with a copy of the hearing decision either at the time of the hearing or no later than 45 days from the date the appeal request was first received by the department.

E. The hearings officer shall notify the absent responsible parent and the custodial parent in writing by certified mail if the appeal is determined to be abandoned because the absent responsible parent did not appear at the hearing.

F. The absent responsible parent or the custodial parent may appeal the hearings officer's decision to the juvenile and domestic relations district court within 10 calendar days of receipt of the hearings officer's decision. An appeal of a tax intercept must be made to the circuit court within 30 days of the date of the hearings officer's decision.

§ 6.3. Appeal of enforcement actions.

A. The absent responsible parent may appeal the actions of the department to enforce a support obligation only under the following conditions:

1. For withholding of earnings; liens; distraint, seizure, and sale; and unemployment compensation benefits intercept the appeal shall be based only on a mistake of fact.

2. For orders to withhold and deliver the appeal shall be based only on (i) a mistake of fact or (ii) whether the funds to be withheld are exempt by law from garnishment.

3. Federal and state tax intercepts may be appealed based only on (i) a mistake of fact or (ii) the validity of the claim.

B. A mistake of fact is based on:

1. An error in the identity of the absent responsible parent, or

2. An error in the amount of current support or past due support.

§ 6.4. Appeal of federal enforcement remedies.

Actions to enforce child support payments through

federal enforcement remedies may not be appealed through the Department of Social Services. Absent responsible parents shall appeal these actions to the federal agency which took the action.

PART VII.
INTERSTATE RESPONSIBILITIES.

When the absent responsible parent and the custodial parent reside in different states, cooperation between these states is necessary.

§ 7.1. Cooperation with other state IV-D agencies.

A. The department shall provide the same services to other state IV-D cases that it provides to its own cases with the following conditions:

1. The request for services must be in writing.

2. The request for services must list the specific services needed.

B. The department shall request in writing the services of other state IV-D agencies when the custodial parent resides in Virginia, but the absent responsible parent resides in another state.

C. Other department responsibilities in providing services to other state IV-D cases and obtaining services from other state IV-D agencies are defined in Part 45, § 303.7 of the Code of Federal Regulations and §§ 63.1-274.6 and 20-88.22 of the Code of Virginia. These regulations are incorporated by reference here.

§ 7.2. Central registry.

A. The department shall manage the flow of interstate correspondence through a Central Registry located in the division's central office. Correspondence will be handled according to the rules established by the state and federal regulations cited by reference above.

B. The Central Registry shall act as the Uniform Reciprocal Enforcement of Support Act State Information Agent required by § 20-88.22 of the Code of Virginia.

PART VIII.
CONFIDENTIALITY AND EXCHANGE OF INFORMATION.

Article 1.
Information Collected by the Department.

§ 8.1. Information collected from state, county, and city offices.

A. State, county, and city offices and agencies shall provide the department with information about absent responsible parents.

B. The department shall use this information to locate and collect child support payments from absent responsible parents.

§ 8.2. Subpoena of financial information.

The department may subpoena financial records from a person, firm, corporation, association, political subdivision, or state agency to corroborate the existence of assets of the absent responsible parent or the custodial parent identified by the Internal Revenue Service.

Article 2.
Information Released by the Department.

§ 8.3. Agencies to whom the department releases information.

A. The department may release information on absent responsible parents to courts and other state child support agencies.

B. The department shall release information concerning the absent responsible parent to consumer credit agencies upon their request.

C. The department may release information concerning custodial parents to courts and other state IV-D agencies as necessary to collect child support on their behalf.

D. The department shall obtain permission from the absent responsible parent or the custodial parent prior to providing information on that person to an entity other than the ones listed above.

E. The department shall release information concerning custodial parents' and absent responsible parents' medical support payments and medical support orders to the Department of Medical Assistance Services.

§ 8.4. Release of information to and from the Internal Revenue Service.

A. The department may not release information provided by the Internal Revenue Service to anyone outside of the department with the following exceptions:

1. The department may release the information to local social service agencies and the courts, but the source of the information may not be released.

2. The department may release information provided by the Internal Revenue Service if that information is verified by a source independent of the IRS.

B. The division director, or a designee, may release information on absent responsible parents to the Internal Revenue Service.

§ 8.5. Request for information from the general public.

The department shall answer requests for information from the general public within five working days of receipt of the request or less as federal and state law may require.

§ 8.6. Requests for information from absent ~~responsible~~ parents and ~~the~~ custodial parents.

A. The department shall release, upon request from the absent responsible parent or custodial parent, copies of court orders, administrative orders, enforcement actions, and fiscal records.

B. The department shall release to the absent responsible parent and to the custodial parent personal information contained in the case record which pertains to the individual requesting the information with one exception. The department may not release medical or psychological information for which the physician providing the information has stated the individual should not have access.

C. The absent responsible parent and the custodial parent may correct, challenge, or explain the personal information which pertains to that individual.

D. The department shall charge a fee for copying case record information. The department shall base the fee on the cost of copying the material.

§ 8.7. Release of health care information.

The department shall provide specific third party liability information to the Department of Medical Assistance Services in order for that agency to pursue the absent responsible parent's medical provider for any Medicaid funds expended for his dependents who are receiving ADC or ADC/FC or who are Medicaid-only clients.

A. The department shall release health care coverage information on ADC, ADC/FC, and Medicaid only cases to the Department of Medical Assistance Services as prescribed in the cooperative agreement between the department and that agency.

B. The department shall release health care coverage information on ADC, ADC/FC, and Medicaid only cases to other state child support agencies upon their request.

C. The department shall release information on health care coverage for nonpublic assistance cases only with the consent of the custodial parent.

PART IX.
RIGHTS AND RESPONSIBILITIES OF THE CUSTODIAL PARENT AND OF THE DEPARTMENT.

Article 1.
Custodial Parent's Rights and Responsibilities.

Throughout this regulation rights and responsibilities of the custodial parents are mentioned in general terms. This section of the regulation does not abridge those rights and responsibilities; it adds to them.

§ 9.1. Custodial parents rights.

A. The department shall give the custodial parent prior notice of major decisions about the child support case.

B. The department shall periodically inform the custodial parent of the progress of the case.

C. The department shall provide the custodial parent with copies of appropriate notices as identified in this regulation.

D. The department shall advise custodial parents who receive ADC of the following rights:

1. The $50 disregard payments, and

2. Eligibility for continued Medicaid coverage when ADC is no longer received.

E. The department shall advise parents who receive ADC, ADC/FC, and Medicaid only of their eligibility for continued child support services when public assistance is no longer received.

F. The department shall inform all non-ADC or ADC/FC clients at the time of application for services of the effect of past receipt of ADC or ADC/FC on the collection of child support payments.

§ 9.2. Custodial parent's responsibilities.

A. Custodial parents must give full and complete information, if known, regarding the absent responsible parent's name, address, social security number, current employment, and employment history and provide new information when learned.

B. Custodial parents must inform the department of any public assistance which was received in the past on behalf of the parent and children.

C. Custodial parents must promptly (i) inform the department of any divorce actions or court actions to establish a child support order, (ii) send to the department copies of any legal documents pertaining to divorce, support, or custody, and (iii) inform the department of any changes in custody or plans for reconciliation with the absent responsible parent.

D. Custodial parents must notify the department if an attorney is hired to handle a child support matter.

E. Custodial parents must notify the department immediately of any change in their financial circumstances.

F. Custodial parents must notify the department in writing regarding any change of their address or name. When possible, the custodial parent shall give this notification 30 days in advance.

Article 2.
Department's Rights and Responsibilities.

§ 9.3. Department's rights.

A. The department shall decide, in a manner consistent with state and federal requirements, the best way to handle a child support case.

B. The department shall decide when to close a case based on federal requirements and the criteria in Part XI.

§ 9.4. Department's responsibilities.

A. The department shall act in a manner consistent with the best interests of the child.

B. The department shall establish a priority system for providing services which will ensure that services are provided in a timely manner.

C. The department shall keep custodial parents advised about the progress of the child support cases and shall include custodial parents in major decisions made about the handling of the child support case.

PART X.
PROCESSING SUPPORT PAYMENTS.

Article 1.
Child Support and Medical Support Payments.

§ 10.1. Disbursement of payments.

A. An absent responsible parent may have multiple child support obligations.

1. Each case shall receive full payment of the current obligation when possible.

2. If the absent responsible parent's disposable earnings do not cover the full payment for each current support order, the department shall prorate the amount withheld among all orders.

B. Current support obligations shall be satisfied before satisfying a past due debt.

C. The method by which child support and medical support payments are disbursed is governed by Part 45, §§ 302.51 and 302.52 of the Code of Federal Regulations which are incorporated by reference.

Article 2.
Payment Recovery.

§ 10.2. Bad checks.

A. When a payment made by an employer or absent responsible parent is not honored upon presentation to the bank on which it was drawn, the department shall first demand payment from the employer or absent responsible parent.

B. If the employer or absent responsible parent does not comply with the demand and the custodial parent is not an ADC or ADC/FC recipient, the department shall recover the payment from the custodial parent according to the methods described in § 10.4.

C. The department shall concurrently take enforcement action against the absent parent or legal action against the employer.

D. If a check received from a custodial parent is not honored upon presentation to the bank upon which it was drawn, the department shall demand payment from the custodial parent.

§ 10.3. Erroneous/duplicate disbursements.

A. When the department sends the custodial parent a payment in error or a duplicate payment, the department shall first demand payment from the custodial parent.

B. If the custodial parent is not an ADC or ADC/FC recipient and does not comply with the demand, the department shall recover the amount of the payment according to the methods described in § 10.4.

§ 10.4. Methods of payment recovery from the custodial parent.

A. If the custodial parent is not an ADC or ADC/FC recipient, the department shall:

1. Intercept and retain payments for past due debt.

2. Retain 10% of the current support payment.

3. Retain the lesser of the balance due or 100% of any intercepted funds.

4. Retain the lesser of the balance due or funds seized from bank accounts.

B. If the custodial parent is an ADC or ADC/FC recipient, the division shall notify the Division of Benefit Programs when an erroneous or duplicate payment has been retained by the client.

PART XI.
CASE CLOSURE.

§ 11.1. General rules.

A. The department shall terminate child support

enforcement services when one of the criteria defined in the Code of Federal Regulations, Title 45, § 303.11 is met.

B. Sixty calendar days prior to closing a case, the department shall notify the custodial parent of its intent to close the case and shall give the reason for the case closure with the exceptions noted in the Code of Federal Regulations, Title 45, § 303.11. The department shall not close the case if the custodial parent supplies additional case information.

C. The department shall continue to provide collection and disbursement services until alternate arrangement for these services has been made.

D. The department shall reopen a closed case if the custodial parent requests the case be reopened because there is a change in circumstance which could lead to the establishment or enforcement of a child support obligation.

E. The department shall purge all closed case records three years after the case is closed pursuant to the Code of Federal Regulations, Title 45, part 74, subpart D.

PART XII.
COST RECOVERY.

Article 1.
General.

§ 12.1. Recovery of fees.

The department shall assess and recover from the absent responsible parent using any mechanism provided in Chapter 13 of Title 63.1:

1. Attorney's fees,

2. Genetic blood testing fees, and

3. Intercept programs' costs.

§ 12.2. Attorney's fees.

A. Attorney fees shall not exceed the amount allowed court-appointed counsel in the district courts pursuant to subdivision 1 of § 19.2-163.

B. The department shall not recover attorneys' fees or costs in any case in which the absent responsible parent prevails.

§ 12.3. Genetic blood testing.

The department shall set the costs of the genetic blood testing at the rate charged the department by the provider of genetic blood testing services.

§ 12.4. Intercept programs.

The department shall charge the absent responsible parent the rate actually charged the department.

/s/ Larry D. Jackson, Commissioner
Virginia Department of Social Services
Date: February 10, 1992

/s/ L. Douglas Wilder
Governor
Date: May 4, 1992

/s/ Ann M. Brown
Deputy Registrar of Regulations
Date: May 5, 1992

STATE CORPORATION COMMISSION

AT RICHMOND, MAY 4, 1992

COMMONWEALTH OF VIRGINIA

At the relation of the
STATE CORPORATION COMMISSION

CASE NO. INS920077

Ex Parte: In the matter
of Adopting Revised Rules Governing
Variable Life Insurance

ORDER TO TAKE NOTICE

WHEREAS, by order entered herein March 5, 1992, the Commission ordered all interested parties to take notice that the Commission would enter an order subsequent to April 22, 1992, adopting a regulation proposed by the Bureau of Insurance entitled "Revised Rules Governing Variable Life Insurance" unless on or before April 22, 1992, any person objecting to the adoption of such regulation filed a request for a hearing, specifying in detail their objection to the adoption of the proposed regulation; and

WHEREAS, as of the date of this order, no interested party has requested a hearing before the Commission to object to the adoption of the proposed regulation; and

THE COMMISSION, having considered the record herein and the recommendation of the Bureau of Insurance, is of the opinion that the regulation should be adopted;

THEREFORE, IT IS ORDERED that the regulation entitled "Revised Rules Governing Variable Life Insurance" which is attached hereto and made a part hereof, should be, and it is hereby, ADOPTED to be effective June 15, 1992.

AN ATTESTED COPY hereof shall be sent by the Clerk of the Commission to the Bureau of Insurance in care of Deputy Commissioner Gerald A. Milsky, who shall forthwith give further notice of the adoption of the regulation by mailing a copy of this order together with a copy of the regulation to all insurance companies licensed to write life insurance in the Commonwealth of Virginia.

Rules Governing Variable Life Insurance (Insurance Regulation No. 26)

Article I - Authority

Section 1. Authority.

This regulation is issued under the authority of § 12.1-13 and § 38.2-3313 of the Code of Virginia and is effective on June 15, 1992.

Article II - Scope

Section 1. Scope.

All life insurance, as defined in § 38.2-102 of the Code of Virginia, payable in variable dollar amounts shall be subject to the provisions of this regulation. In the event of conflict between the provisions of this regulation and the provisions of any other regulation issued by the Commission, the provisions of this regulation shall be controlling as to variable life insurance.

Nothing contained in this regulation shall be construed to relieve an insurer of complying with the statutory requirements set forth in Title 38.2 of the Code of Virginia to the extent such statutory requirements may be deemed by the Commission to be applicable to variable life insurance.

Article III - Definitions

As used in this regulation:

Section 1. Affiliate.

"Affiliate" of an insurer means any person, directly or indirectly, controlling, controlled by, or under common control with such insurer; any person who regularly furnishes investment advice to such insurer with respect to its separate accounts for which a specific fee or commission is charged; or any director, officer, partner, or employee of any such insurer, controlling or controlled person, or person providing investment advice or any member of the immediate family of such person.

Section 2. Agent.

"Agent" means any person, corporation, partnership, or other legal entity which is licensed by this Commonwealth as a life and health insurance agent.

Section 3. Assumed Investment Rate.

"Assumed investment rate" means the rate of investment return which would be required to be credited to a variable life insurance policy, after deduction of charges for taxes, investment expenses, and mortality and expense guarantees to maintain the variable death benefit equal at all times to the amount of death benefit, other than incidental insurance benefits, which would be payable under the plan of insurance if the death benefit did not vary according to the investment experience of the separate account.

Section 4. Benefit Base.

"Benefit base" means the amount to which the net investment return is applied.

Section 5. Commission.

"Commission" means the State Corporation Commission.

Section 6. Control.

"Control" (including the terms "controlling", "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing more than ten (10) percent of the voting securities of any other person. This presumption may be rebutted by a showing made to the satisfaction of the Commission that control does not exist in fact. The Commission may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support such determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

Section 7. Flexible Premium Policy.

"Flexible premium policy" means any variable life insurance policy other than a scheduled premium policy as specified in § 14 of this Article.

Section 8. General Account.

"General Account" means all assets of the insurer other than assets in separate accounts established pursuant to § 38.2-3113 of the Code of Virginia or pursuant to the corresponding section of the insurance laws of the state of domicile of a foreign or alien insurer, whether or not for variable life insurance.

Section 9. Incidental Insurance Benefit.

"Incidental insurance benefit" means all insurance benefits in a variable life insurance policy, other than the variable death benefit and the minimum death benefit, including but not limited to accidental death and dismemberment benefits, disability benefits, guaranteed insurability options, family income, or term riders.

Section 10. Minimum Death Benefit.

"Minimum death benefit" means the amount of the guaranteed death benefit, other than incidental insurance benefits, payable under a variable life insurance policy regardless of the investment performance of the separate account.

Section 11. Net Investment Return.

"Net investment return" means the rate of investment return in a separate account to be applied to the benefit base.

Section 12. Person.

"Person" means any association, aggregate of individuals, business, company, corporation, individual, joint stock company, organization, partnership, receiver, reciprocal, or interinsurance exchange, trustee or society.

Section 13. Policy Processing Day.

"Policy processing day" means the day on which charges authorized in the policy are deducted from the policy's cash value.

Section 14. Scheduled Premium Policy.

"Scheduled premium policy" means any variable life insurance policy under which both the amount and timing of premium payments are fixed by the insurer.

Section 15. Separate Account.

"Separate account" means a separate account established pursuant to § 38.2-3113 of the Code of Virginia or pursuant to the corresponding section of the insurance laws of the state of domicile of a foreign or alien insurer.

Section 16. Variable Death Benefit.

"Variable death benefit" means the amount of the death benefit, other than incidental insurance benefits, payable under a variable life insurance policy dependent on the investment performance of the separate account, which the insurer would have to pay in the absence of any minimum death benefit.

Section 17. Variable Life Insurance Policy.

"Variable life insurance policy" means any policy or contract that provides for a form of life insurance as defined in § 38.2-102 of the Code of Virginia, the amount or duration of which varies according to the investment experience of any separate account or accounts established and maintained by the insurer as to such policy, pursuant to §§ 38.2-3114 and 38.2-3113 of the Code of Virginia or pursuant to the corresponding section of the insurance laws of the state of domicile of a foreign or alien insurer.

Article IV - Qualification of Insurer to Issue Variable Life Insurance

The following requirements are applicable to all insurers either seeking authority to issue variable life insurance in this Commonwealth or having authority to issue variable life insurance in this Commonwealth.

Section 1. Licensing And Approval to do Business in this Commonwealth.

An insurer shall not deliver or issue for delivery any variable life insurance policy in this Commonwealth unless:

a. the insurer is licensed to transact a life insurance business in this Commonwealth;

b. the insurer has obtained the necessary written approvals of the Commission for the conduct of a variable life insurance business in this Commonwealth. The Commission shall grant such written approval only after it has found that:

(1) the plan of operation for the issuance of variable life insurance policies is not unsound;

(2) the general character, reputation, and experience of the management and those persons or firms proposed to supply consulting, investment, administrative, or custodial services to the insurer are such as to reasonably assure competent operation of the variable life insurance business of the insurer in this Commonwealth; and

(3) the present and foreseeable future financial condition of the insurer and its method of operation in connection with the issuance of such policies is not likely to render its operation hazardous to the public or its policyholders in this Commonwealth. The Commission shall consider, amount other things:

(A) the history of operation and financial condition of the insurer;

(B) the qualifications, fitness, character, responsibility, reputation, and experience of the officers and directors and other management of the insurer and those persons or firms proposed to supply consulting, investment, administrative, or custodial services to the insurer;

(C) the applicable law and regulations under which the insurer is authorized in its state of domicile to issue variable life insurance policies. The state of entry of an alien insurer shall be deemed its state of domicile for this purpose; and

(D) if the insurer is a subsidiary of, or is affiliated by common management or ownership with another company, its relationship to such other company and the degree to which the requesting insurer, as well as the other company, meet these standards.

Section 2. Filing for Approval to do Business in this Commonwealth.

The Commission may, at its discretion, require that an insurer, before it delivers or issues for delivery any variable life insurance policy in this Commonwealth, file the following information for the consideration of the Commission in making the determination required by Section 1, subsection b of this Article:

a. copies of and a general description of the variable life insurance policies it intends to issue; however, approval of the insurer pursuant to this Article shall not be construed as approval of the forms pursuant to Article V of this regulation;

b. a general description of the methods of operation of the variable life insurance business of the insurer; including methods of distribution of policies and the names of those persons or firms proposed to supply consulting, investment, administrative, custodial or distribution services to the insurer;

c. with respect to any separate account maintained by an insurer for any variable life insurance policy, a statement of the investment policy the issuer intends to follow for the investment of the assets held in such separate account, and a statement of procedures for changing such investment policy. The statement of investment policy shall include a description of the investment objectives intended for the separate account;

d. a description of any investment advisory services contemplated as required by Section 10 of Article VII;

e. a copy of the statutes and regulations of the state of domicile of the insurer under which it is authorized to issue variable life insurance policies; and

f. biographical data with respect to officers and directors of the insurer on the National Association of Insurance Commissioners Uniform Biographical Data Form; and

g. a statement of the insurer's actuary describing the mortality and expense risks which the insurer will bear under the policy.

Section 3. Standards of Suitability.

Every insurer seeking approval to enter into the variable life insurance business in this Commonwealth shall establish and maintain a written statement specifying the Standards of Suitability to be used by the insurer. Such Standards of Suitability shall specify that no recommendations shall be made to an applicant to purchase a variable life insurance policy and that no variable life insurance policy or certificate shall be issued in the absence of reasonable grounds to believe that the purchase of such policy or certificate is not unsuitable for such applicant on the basis of information furnished after reasonable inquiry of such applicant concerning the applicant's insurance and investment objectives, financial situation and needs, and any other information known to the insurer or to the agent making the recommendation.

Section 4. Use of Sales Materials.

An insurer authorized to transact variable life insurance business in this Commonwealth shall not use any sales material, advertising material, or descriptive literature or other materials of any kind in connection with its variable life insurance business in this state which is false,

misleading, deceptive, or inaccurate.

Variable life insurance marketing communications shall be subject to the additional requirements of Insurance Regulation No. 23, Rules Governing Life Insurance and Annuity Marketing Practices adopted by the Commission in Case No. INS810107.

Section 5. Requirements Applicable To Contractual Services.

Any material contract between an insurer and suppliers of consulting, investment, administrative, sales, marketing, custodial, or other services with respect to variable life insurance operations shall be in writing and provide that the supplier of such services shall furnish the Commission with any information or reports in connection with such services which the Commission may request in order to ascertain whether the variable life insurance operations of the insurer are being conducted in a manner consistent with these regulations and any other applicable law or regulations.

Section 6. Reports to the Commission.

Any insurer authorized to transact the business of variable life insurance in this Commonwealth shall submit to the Commission, in addition to any other materials which may be required by this regulation or any other applicable laws or regulations:

a. an annual statement of the business of its separate account or accounts in such form as may be prescribed by the Commission; and

b. prior to its use in this Commonwealth any information furnished to applicants as provided for in Article VIII; and

c. prior to its use in this Commonwealth the form of any of the Reports to Policyholders as provided for in Article X; and

d. such additional information concerning its variable life insurance operations or its separate accounts as the Commission shall deem necessary,

Any material submitted to the Commission under this Section shall be disapproved if it is found to be false, misleading, deceptive, or inaccurate in any material respect and, if previously distributed, the Commission may require the distribution of amended material.

Section 7. Authority of Commission to Disapprove.

Any material required to be filed with and approved by the Commission shall be subject to disapproval or withdrawal of approval if at any time such material is found by the Commission not to comply with the standards established by this regulation, or any other applicable statute or regulation.

Article V - Insurance Policy Requirements

The Commission shall not approve any variable life insurance form filed pursuant to this regulation unless it conforms to the requirements of this Article and all other statutory and regulatory requirements deemed applicable by the Commission. No policy or certificate approved prior to the effective date of this regulation shall be delivered or issued for delivery in this Commonwealth until it has been approved by the Commission under the requirements established by this regulation.

Section 1. Filing of Variable Life Insurance Policies.

All variable life insurance policies or certificates, and all riders, endorsements, applications and other documents which are to be attached to and made a part of the policy or certificate and which relate to the variable nature of the policy, shall be filed with and approved by the Commission prior to such forms being put in force, issued for delivery, or delivered in this Commonwealth.

a. The procedures and requirements for such filing and approval shall be, to the extent appropriate and not inconsistent with this regulation, the same as those otherwise applicable to other life insurance forms.

b. The Commission may approve variable life insurance policies and related forms with provisions the Commission deems to be not less favorable to the policyholder and the beneficiary than those required by this regulation.

Section 2. Mandatory Policy Benefit and Design Requirements.

Variable life insurance policies delivered or issued for delivery in this Commonwealth shall comply with the following minimum requirements.

a. Mortality and expense risks shall be borne by the insurer. The mortality and expense charges shall be subject to the maximums stated in the contract.

b. For scheduled premium policies, a minimum death benefit shall be provided in an amount at least equal to the initial face amount of the policy less any indebtedness so long as premiums are duly paid.

c. The policy shall reflect the investment experience of one or more separate accounts established and maintained by the insurer which shall be set forth in the policy. The insurer must demonstrate that the reflection of the investment experience in variable life insurance policy is actuarially sound.

d. Each variable life insurance policy shall be credited with the full amount of the net investment return applied to the benefit base.

e. Any changes in variable death benefits of each variable life insurance policy shall be determined at least

annually.

f. The cash value of each variable life insurance policy shall be determined at least monthly. The method of computation of cash values and other nonforfeiture benefits, as described either in the policy or in a statement filed with the insurance supervisory official of the state in which the policy is delivered, or issued for delivery, shall be in accordance with actuarial procedures that recognize the variable nature of the policy. The method of computation must be such that, if the net investment return credited to the policy at all times from the date of issue should be equal to the assumed investment rate with premiums and benefits determined accordingly under the terms of the policy, then the resulting cash values and other nonforfeiture benefits must be at least equal to the minimum values required by § 38.2-3200 through § 38.2-3229 (Standard Nonforfeiture Law) of the Code of Virginia for a general account policy with such premiums and benefits. The assumed investment rate shall not exceed the maximum interest rate permitted under the Standard Nonforfeiture Law of this Commonwealth. If the policy does not contain an assumed investment rate this demonstration shall be based on the maximum interest rate permitted under the Standard Nonforfeiture Law. The method of computation may disregard incidental minimum guarantees as to the dollar amounts payable. Incidental minimum guarantees include, for example, but are not to be limited to, a guarantee that the amount payable at death or maturity shall be at least equal to the amount that otherwise would have been payable if the net investment return credited to the policy at all times from the date of issue had been equal to the assumed investment rate.

g. The computation of values required for each variable life insurance policy may be based upon such reasonable and necessary approximations as are acceptable to the Commission.

Section 3. Mandatory Policy Provisions.

Each variable life insurance policy filed for approval in this Commonwealth shall in addition to other applicable statutory requirements, contain the following:

a. The first page of each policy shall contain:

(1) A prominent statement in boldface type at least two points larger than the type used for policy provisions, printed in all capital letters, that the amount or duration of death benefits may be variable or fixed under specified conditions;

(2) A prominent statement in boldface type at least two points larger than the type used for policy provisions, printed in all capital letters, that cash values may increase or decrease in accordance with the experience of the separate account subject to any specified minimum guarantees;

(3) A prominent statement in contrasting color and in boldface type at least two points larger than the type used for policy provisions, printed in all capital letters, describing any minimum death benefit required pursuant to Section 2b of this Article V;

(4) A statement describing the method, or a reference to the policy provision which describes the method, for determining the amount of insurance payable at death;

(5) When appropriate a prominent statement in boldface type at least two points larger than the type used for policy provisions, printed in all capital letters, that the policy loan value is less than one hundred percent (100%) of the policy's cash value surrender value;

b. (1) For scheduled premium policies, a provision for a grace period of not less than thirty-one days from the premium due date which shall provide that where the premium is paid within the grace period, policy values will be the same, except for the deduction of any overdue premium, as if the premium were paid on or before the due date.

(2) For flexible premium policies, a provision for a grace period beginning on the policy processing day when the total charges authorized by the policy that are necessary to keep the policy in force until the next policy processing day exceed the amounts available under the policy to pay such charges in accordance with the terms of the policy. Such grace period shall end on a date not less than 61 days after the mailing date of the report to policyholders required by Paragraph 3 of Article X.

The death benefit payable during the grace period will equal the death benefit less any outstanding indebtedness and less any overdue charges at the time of the last valuation of the policy preceding the beginning of the grace period.

c. (1) For scheduled premium policies, a provision that the policy will be reinstated at any time within three years from the date of default upon the written application of the insured, and evidence of insurability, including good health, satisfactory to the insurer, unless the cash surrender value has been paid or the period of extended insurance has expired, upon the payment of any outstanding indebtedness arising subsequent to the end of the grace period following the date of default together with accrued interest thereon to the date of reinstatement and payment of an amount not exceeding the greater of:

(A) All overdue premiums with interest at a rate not exceeding six (6) percent per year compounded annually and any indebtedness in effect at the end of the grace period following the date of default with interest at a rate as provided in § 38.2-3308 of the Code of Virginia; or

(B) 110 percent of the increase in cash value resulting from reinstatement plus all overdue premiums for incidental insurance benefits with interest at a rate not exceeding six (6) percent per annum compounded annually.

(2) For flexible premium policies a provision that the policy will be reinstated at any time within three years from the date of default upon the written application of the insured and evidence of insurability, including good health, satisfactory to the insurer, unless the cash surrender value has been paid or the period of extended insurance has expired, upon the payment of any outstanding indebtedness arising subsequent to the end of the grace period following the date of default together with accrued interest thereon to the date of reinstatement and payment of an amount not exceeding the greater of:

(A) a charge not to exceed three months cost of insurance; or

(B) 110 percent of the increase in cash value resulting from reinstatement plus all overdue premiums for incidental insurance benefits with interest at a rate note exceeding six (6) percent per annum compounded annually.

d. A full description of the benefit base and of the method of calculation and application of any factors used to adjust variable benefits under the policy;

e. A provision designating the separate account to be used and stating that:

(1) The assets of such separate account shall be available to cover the liabilities of the general account of the insurer only to the extent that the assets of the separate account exceed the liabilities of the separate account arising under the variable life insurance policies supported by the separate account;

(2) The assets of such separate account shall be valued at least as often as any policy benefits vary but at least monthly.

f. A designation of the officers who are empowered to make an agreement or representation on behalf of the insurer;

g. A provision setting forth conditions or requirements as to the designation, or change of designation, of a beneficiary and a provision for disbursement of benefits in the absence of a beneficiary designation;

h. A statement of any conditions or requirements concerning the assignment of the policy;

i. A description of any adjustments in policy values to be made in the event of misstatement of age or sex of the insured;

j. A provision stating that the investment policy of the separate account shall not be changed without the approval of the Insurance Supervisory Official of the state of domicile of the insurer, and that the approval process is on file with the Commission;

k. A provision that payment of variable death benefits in excess of any minimum death benefits, cash values, policy loans, or partial withdrawals (except when used to pay premiums) or partial surrenders may be deferred:

(1) For up to six months from the date of request, if such payments are based on policy values which do not depend on the investment performance of the separate account, or

(2) Otherwise, for any period during which the New York Stock Exchange is closed for trading (except for normal holiday closing) or when the Securities and Exchange Commission has determined that a state of emergency exists which may make such payment impractical;

l. If settlement options are provided, at least one such option shall be provided on a fixed basis only;

m. A description of the basis for computing the cash value and the surrender value under the policy shall be included;

n. Premiums or charges for incidental insurance benefits shall be stated separately;

o. The insurer may establish a reasonable minimum cash value below which any nonforfeiture insurance options will not be available. Upon termination of any policy if there is any cash value, the cash value shall be returned to the owner of the policy.

Section 4. Policy Loan Provisions.

Every variable life insurance policy, other than term insurance policies and pure endowment policies, delivered or issued for delivery in this Commonwealth shall contain, in addition to other applicable statutory requirements, provisions which are not less favorable to the policyholder than the following:

a. A provision for policy loans after the policy has been in force for two full years which provides the following:

(1) For scheduled premium policies, whenever the indebtedness exceeds the cash surrender value, the insurer shall give notice of any intent to cancel the policy if the excess indebtedness is not repaid within thirty-one days after the date of mailing of such notice.

(2) The policy may provide that if, at any time, so long as premiums are duly paid, the variable death benefit is less than it would have been if no loan or

withdrawal had ever been made, the policyowner may increase such variable death benefit up to what it would have been if there had been no loan or withdrawal by paying an amount not exceeding 110 percent of the corresponding increase in cash value and by furnishing such evidence of insurability as the insurer may request.

(3) The policy may specify a reasonable minimum amount which may be borrowed at any time but such minimum shall not apply to any automatic premium loan provision.

(4) The policy loan provisions shall be constructed so that variable life insurance policyholders who have not exercised such provisions are not disadvantaged by the exercise thereof.

(5) Any amount paid to the policyholders upon the exercise of any policy loan provision shall be withdrawn from the separate account and shall be returned to the separate account upon repayment except that a stock insurer may provide the amount for policy loans from the general account.

(6) At least ninety percent (90%) of the policy's cash surrender value may be borrowed.

Section 5. Other Policy Provisions.

The following provisions may in substance be included in a variable life insurance policy or related form delivered or issued for delivery in this Commonwealth:

a. For any increase in death benefits which results from an application of the owner subsequent to the policy issue date, the policy may provide an exclusion for suicide within two years of such increase as to the increased amount of death benefits. Any refund due under a suicide exclusion may be adjusted to reflect the investment activity of the variable account;

b. Incidental insurance benefits may be offered on a fixed or variable basis;

c. A provision allowing the policyholder to elect in writing in the application for the policy or thereafter an automatic premium loan on a basis not less favorable than that required of policy loans under Section 4 of this Article, except that a restriction that no more than two consecutive premiums can be paid under this provision may be imposed;

d. A provision allowing the policyholder to make partial withdrawals;

e. Any other policy provision approved by the Commission.

Article VI - Reserve Liabilities For Variable Life Insurance

Section 1. Variable Life Policies.

Reserve liabilities for variable life insurance policies shall be established under § 38.2-1307 through § 38.2-1315 of the Code of Virginia, the Standard Valuation Law, in accordance with actuarial procedures that recognize the variable nature of the benefits provided and any mortality guarantees.

Section 2. Scheduled Premium Policies.

For scheduled premium policies, reserve liabilities for the guaranteed minimum death benefit shall be the reserve needed to provide for the contingency of death occurring when the guaranteed minimum death benefit exceeds the death benefit that would be paid in the absence of the guarantee, and shall be maintained in the general account of the insurer and shall be not less than the greater of the following minimum reserves:

a. The aggregate total of the term costs, if any, covering a period of one full year from the valuation date, of the guarantee on each variable life insurance contract, assuming an immediate one-third depreciation in the current value of the assets of the separate account followed by a net investment return equal to the assumed investment rate; or

b. The aggregate total of the "attained age level" reserves on each variable life insurance contract. The "attained age level" reserve on each variable life insurance contract shall not be less than zero and shall equal the "residue", as described in paragraph (1), of the prior year's "attained age level" reserve on the contract, with any "residue", increased or decreased by a payment computed on an attained age basis as described in paragraph (2) below.

(1) The "residue" of the prior year's "attained age level" reserve on each variable life insurance contract shall not be less than zero and shall be determined by adding interest at the valuation interest rate to such prior year's reserve, deducting the tabular claims based on the "excess", if any, of the guaranteed minimum death benefit over the death benefit that would be payable in the absence of such guarantee, and dividing the net result by the tabular probability of survival. The "excess" referred to in the preceding sentence shall be based on the actual level of death benefits that would have been in effect during the preceding year in the absence of the guarantee, taking appropriate account of the reserve assumptions regarding the distribution of death claim payments over the year.

(2) The payment referred to in Subsection 2b of this Article shall be computed so that the present value of a level payment of that amount each year over the future premium paying period of the contract is equal to (A) minus (B) minus (C), where (A) is the present value of the future guaranteed minimum death

benefits, (B) is the present value of the future death benefits that would be payable in the absence of such guarantee, and (C) is any "residue", as described in paragraph (1), of the prior year's "attained age level" reserve on such variable life insurance contract. If the contract is paid-up, the payment shall equal (A) minus (B) minus (C). The amounts of future death benefits referred to in (B) shall be computed assuming a net investment return of the separate account which may differ from the assumed investment rate and§or the valuation interest rate but in no event may exceed the maximum interest rate permitted for the valuation of life contracts.

c. The valuation interest rate and mortality table used in computing the two minimum reserves described in (a) and (b) above shall conform to permissible standards for the valuation of life insurance contracts. In determining such minimum reserve, the company may employ suitable approximations and estimates, including but not limited to groupings and averages.

Section 3. Flexible Premium Policies.

For flexible premium policies, reserve liabilities for any guaranteed minimum death benefit shall be maintained in the general account of the insurer and shall be not less than the aggregate total of the term costs, if any, covering the period provided for in the guarantee not otherwise provided for by the reserves held in the separate account assuming an immediate one-third depreciation in the current value of the assets of the separate account followed by a net investment return equal to the valuation interest rate.

The valuation interest rate and mortality table used in computing this additional reserve, if any, shall conform to permissible standards for the valuation of life insurance contracts. In determining such minimum reserve, the company may employ suitable approximations and estimates, including but not limited to groupings and averages.

Section 4. Fixed Incidental Insurance Benefits.

Reserve liabilities for all fixed incidental insurance benefits and any guarantees associated with variable incidental insurance benefits shall be maintained in the general account and reserve liabilities for all variable aspects of the variable incidental insurance benefits shall be maintained in a separate account, in amounts determined in accordance with the actuarial procedures appropriate to such benefit.

Article VII - Separate Accounts

The following requirements apply to the establishment and administration of variable life insurance separate accounts by any domestic insurer.

Section 1. Establishment and Administration of Separate Accounts.

Any domestic insurer issuing variable life insurance shall establish one or more separate accounts pursuant to § *38.2-3113* ~~38.1-443~~ of the Code of Virginia.

a. If no law or other regulation provides for the custody of separate account assets and if such insurer is not the custodian of such separate account assets, all contracts for custody of such assets shall be in writing and the Commission shall have authority to review and approve or disapprove of both the terms of any such contract and the proposed custodian prior to the transfer of custody.

b. Such insurer shall not without the prior written approval of the Commission employ in any material capacity in connection with the handling of separate account assets any person who:

(1) Within the last ten years has been convicted of any felony or a misdemeanor arising out of such person's conduct involving embezzlement, fraudulent conversion, or misappropriation of funds or securities or involving violation of Sections 1341, 1342, or 1343 of Title 18, United States Code; or

(2) Within the last ten years has been found by any state regulatory authority to have violated or has acknowledged violation of any provision of any state insurance law involving fraud, deceit, or knowing misrepresentation; or

(3) Within the last ten years has been found by federal or state regulatory authorities to have violated or has acknowledged violation of any provision of federal or state securities laws involving fraud, deceit, or knowing misrepresentation.

c. All persons with access to the cash, securities, or other assets of the separate account shall be under bond in the amount of not less than a value indexed to the National Association of Insurance Commissioners fidelity bonding recommendations regarding personnel handling general account assets or as determined by the Commission.

d. The assets of such separate accounts shall be valued at least as often as variable benefits are determined but in any event at least monthly.

Section 2. Amounts in the Separate Account.

The insurer shall maintain in each separate account assets with a value at least equal to the greater of the valuation reserves for the variable portion of the variable life insurance policies or the benefit base for such policies.

Section 3. Investment by the Separate Account.

a. No sale, exchange, or other transfer of assets may be

made by an insurer or any of its affiliates between any of its separate accounts or between any other investment account and one or more of its separate accounts unless:

(1) In case of a transfer into a separate account, such transfer is made solely to establish the account or to support the operation of the policies with respect to the separate account to which the transfer is made; and

(2) Such transfer, whether into or from a separate account, is made by a transfer of cash; but other assets may be transferred if approved by the Commission in advance.

b. The separate account shall have sufficient net investment income and readily marketable assets to meet anticipated withdrawals under policies funded by the account.

Section 4. Limitations on Ownership.

a. A separate account shall not purchase or otherwise acquire the securities of any issuer, other than securities issued or guaranteed as to principal and interest by the United States Government, if immediately after such purchase or acquisition the value of such investment, together with prior investments of such account in such security valued as required by these regulations, would exceed ten (10) percent of the value of the assets of the separate account. The Commission may waive this limitation in writing if it believes such waiver will not render the operation of the separate account hazardous to the public or the policyholders in this Commonwealth.

b. No separate account shall purchase or otherwise acquire the voting securities of any issuer if as a result of such acquisition the insurer and its separate accounts in the aggregate will own more than ten (10) percent of the total issued and outstanding voting securities of such issuer. The Commission may waive this limitation in writing if it believes such waiver will not render the operation of the separate account hazardous to the public or the policyholders in this Commonwealth or jeopardize the independent operation of the issuer of such securities.

c. The percentage limitation specified in subsection a of this section shall not be construed to preclude the investment of the assets of separate accounts in shares of investment companies registered pursuant to the Investment Company Act of 1940 or other pools of investment assets if the investments and investment policies of such investment companies or asset pools comply substantially with the provisions of Section 3 of this Article and other applicable portions of this regulation.

Section 5. Valuation of Separate Account Assets.

Investments of the separate account shall be valued at their market value on the date of valuation, or at amortized cost if it approximates market value.

Section 6. Separate Account Investment Policy.

The investment policy of a separate account operated by a domestic insurer filed under Section 2c of Article IV shall not be changed without first filing such change with the Commission.

(1) Any change filed pursuant to this section shall be effective sixty days after the date it was filed with the Commission, unless the Commission notifies the insurer before the end of such sixty day period of its disapproval of the proposed change. At any time the Commission may, after notice and opportunity to be heard, disapprove any change that has become effective pursuant to this section.

(2) The Commission may disapprove the change if it determines that the change would be detrimental to the interests of the policyholders participating in such separate account.

Section 7. Charges Against Separate Account.

The insurer must disclose to the policyholder and§or certificateholder in writing, prior to or at the time of delivery of the policy or certificate, all charges that may be made against the separate account, including, but not limited to, the following:

(1) Taxes or reserves for taxes attributable to investment gains and income of the separate account;

(2) Actual cost of reasonable brokerage fees and similar direct acquisition and sale costs incurred in the purchase of sale of separate account assets;

(3) Actuarially determined costs of insurance (tabular costs) and the release of separate account liabilities;

(4) Charges for administrative expenses and investment management expenses, including internal costs attributable to the investment management of assets of the separate account;

(5) A charge, at a rate specified in the policy, for mortality and expense guarantees;

(6) Any amounts in excess of those required to be held in the separate accounts;

(7) Charges for incidental insurance benefits.

Section 8. Standards of Conduct.

Every insurer seeking approval to enter into the variable life insurance business in this Commonwealth shall adopt by formal action of its board of directors a written statement specifying the Standards of Conduct of the insurer, its officers, directors, employees, and affiliates with respect to the purchase or sale of investments of separate accounts. Such Standards of Conduct shall be

binding on the insurer and those to whom it refers. A code or codes of ethics meeting the requirements of Section 17j under the Investment Company Act of 1940 and applicable rules and regulations thereunder shall satisfy the provisions of this section.

Section 9. Conflicts of Interest.

Rules under any provision of the insurance laws of this Commonwealth or any regulation applicable to the officers and directors of insurance companies with respect to conflicts of interest shall also apply to members of any separate accounts committee or other similar body.

Section 10. Investment Advisory Services to a Separate Account.

An insurer shall not enter into a contract under which any person undertakes, for a fee, to regularly furnish investment advice to such insurer with respect to its separate accounts maintained for variable life insurance policies unless:

(1) The person providing such advice is registered as an investment advisor under the Investment Advisers Act of 1940; or

(2) The person providing such advice is an investment manager under the Employee Retirement Income Security Act of 1974 with respect to the assets of each employee benefit plan allocated to the separate account; or

(3) The insurer has filed with the Commission and continues to file annually the following information and statements concerning the proposed advisor:

(a) The name and form of organization, state of organization, and its principal place of business;

(b) The names and addresses of its partners, officers, directors, and persons performing similar functions, or if such an investment advisor be an individual, of such individual;

(c) A written Standard of Conduct complying in substance with the requirements of § 8 of this Article which has been adopted by the investment advisor and is applicable to the investment advisor, its officers, directors, and affiliates;

(d) A statement provided by the proposed advisor as to whether the advisor or any person associated therewith:

(i) Has been convicted within ten years of any felony or misdemeanor arising out of such person's conduct as an employee, salesman, officer or director or an insurance company, a banker, an insurance agent, a securities broker, or an investment advisor involving embezzlement, fraudulent conversion, or misappropriation of funds or securities, or involving the violation of Sections 1341, 1342, or 1343 of Title 18 of United States Code;

(ii) Has been permanently or temporarily enjoined by order, judgment, or decree of any court of competent jurisdiction from acting as an investment advisor, underwriter, broker, or dealer, or as an affiliated person or as an employee of any investment company, bank, or insurance company, or from engaging in or continuing any conduct or practice in connection with any such activity;

(iii) has been found by federal or state regulatory authorities to have willfully violated or have acknowledged willful violation of any provision of federal or state securities laws or state insurance laws or of any rule or regulation under any such laws; or

(iv) has been censured, denied an investment advisor registration, had a registration as an investment advisor revoked or suspended, or has been barred or suspended from being associated with an investment advisor by order of federal or state regulatory authorities; and

(4) Such investment advisory contract shall be in writing and provide that it may be terminated by the insurer without penalty to the insurer or the separate account upon no more than sixty days' written notice to the investment advisor.

The Commission may, after notice and opportunity for hearing, by order require such investment advisory contract to be terminated if it deems continued operation thereunder to be hazardous to the public or the insurer's policyholders.

Article VIII - Information Furnished to Applicants

An insurer delivering or issuing for delivery in this Commonwealth variable life insurance policies shall deliver to the applicant for the policy or certificate, and obtain a written acknowledgement of receipt from such applicant coincident with or prior to the execution of the application, the following information. The requirements of this Article shall be deemed to have been satisfied to the extent that a disclosure containing information required by this Article is delivered, either in the form of (1) a prospectus included in the requirements of the Securities Act of 1933 and which was declared effective by the Securities and Exchange Commission; or (2) all information and reports required by the Employee Retirement Income Security Act of 1974 if the policies are exempted from the registration requirements of the Securities Act of 1933 pursuant to Section 3(a)(2) thereof.

1. A summary explanation, in non-technical terms, of the principal features of the policy, including a description of the manner in which the variable benefits will reflect the investment experience of the

separate account and the factors which affect such variation. Such explanation must include notices of the provisions required by § 38.2-3301 and § 38.2-3304 of the Code of Virginia regarding the ten day free look and entire contract provisions of the policy or certificate.

2. A statement of the investment policy of the separate account, including:

(a) A description of the investment objectives intended for the separate account and the principal types of investments intended to be made; and

(b) any restriction or limitations on the manner in which the operations of the separate account are intended to be conducted.

3. A statement of the net investment return of the separate account for each of the last ten years or such lesser period as the separate account has been in existence.

4. A statement of the charges levied against the separate account during the previous year.

5. A summary of the method to be used in valuing assets held by the separate account.

6. A summary of the federal income tax aspects of the policy applicable to the insured, the policyholder and the beneficiary.

7. Illustrations of benefits payable under the variable life insurance contract. Such illustrations shall be prepared by the insurer and shall not include projections of past investment experience into the future or attempted predictions of future investment experience, provided that nothing contained herein prohibits use of hypothetical assumed rates of return to illustrate possible level of benefits if it is made clear that such assumed rates are hypothetical only.

8. If there are any guaranteed elements to the accumulation of cash values, an illustration or proposal must separately display:

a) The guaranteed cash values and

b) The guaranteed loan values if the loan values are less than one hundred percent (100%) of the cash values.

9. If the loan value is less than one hundred percent (100%) of the cash surrender value such fact must be shown as a percentage of cash surrender value and such fact must be prominently displayed on any proposal or in any illustration.

Article IX - Applications

The application for a variable life insurance policy shall contain:

1. A prominent statement in boldface capital letters that the death benefit may be variable or fixed under specified conditions;

2. A prominent statement in boldface capital letters that cash values may increase or decrease in accordance with the experience of the separate account (subject to any specified minimum guarantees);

3. Questions based on the insurer's standards of suitability so that in view of the applicant's other insurance, investment objectives, age, earnings, marital status, number and age of dependents, current life insurance program, the value of savings and other assets, net worth, and any other pertinent information, the insurer may determine that variable life insurance is suitable for the applicant.

Article X - Reports to Policyholders

Any insurer delivering or issuing for delivery in this Commonwealth any variable life insurance policies or certificates shall mail to each variable life insurance policyholder and certificateholder at his or her last known address the following reports:

1. Within thirty days after each anniversary of the policy, a statement or statements with serialized pages of the cash surrender value, loan value if less than one hundred percent (100%) of the cash surrender value, death benefit, any partial withdrawal or policy loan, any interest charge, and any optional payments allowed pursuant to Section 4 of Article V under the policy computed as of the policy anniversary date. Provided, however, that such statement may be furnished within thirty days after a specified date in each policy year so long as the information contained therein is computed as of a date not more than sixty days prior to the mailing of such notice. This statement shall state that, in accordance with the investment experience of the separate account, the cash values and the variable death benefit may increase or decrease, and shall prominently identify any value described therein which may be recomputed prior to the next statement required by this section. If the policy guarantees that the variable death benefit on the next policy anniversary date will not be less than the variable death benefit specified in such statement, the statement shall be modified to so indicate. For flexible premium policies, the report must contain a reconciliation of the change since the previous report in cash value and cash surrender value, if different, because of payments made (less deductions for expense charges), withdrawals, investment experience, insurance charges and any other charges made against the cash value. The report must show the loan value separately if the loan value

is less than one hundred percent (100%) of the policy's cash surrender value. In addition, the report must show the projected cash value, and cash surrender value if different from the projected cash value, and projected loan value if less than one hundred percent (100%) of the policy's projected cash surrender value, as of one year from the end of the period covered by the report assuming that: (i) planned periodic premiums, if any, are paid as scheduled; (ii) guaranteed costs of insurance are deducted; and (iii) the net investment return is equal to the guaranteed rate or, in the absence of a guaranteed rate, is not greater than zero. If the projected value is less than zero, a warning message must be included that states that the policy may be in danger of terminating without value in the next 12 months unless additional premium is paid.

2. Annually, a statement or statements including:

a. A summary of the financial statement of the separate account based on the annual statement last filed with the Commission;

b. The net investment return of the separate account for the last year and, for each year after the first, a comparison of the investment rate of the separate account during the last year with the investment rate during prior years, up to a total of not less than five years when available;

c. A list of investments held by the separate account as of a date not earlier than the end of the last year for which an annual statement was filed with the Commission;

d. Any charges levied against the separate account during the previous year;

e. A statement of any change, since the last report, in the investment objective and orientation of the separate account, in any investment restriction or material quantitative or qualitative investment requirement applicable to the separate account or in the investment advisor of the separate account.

3. For flexible premium policies, a report must be sent to the policyholder if the amounts available under the policy on any policy processing day to pay the charges authorized by the policy are less than the amount necessary to keep the policy in force until the next following policy processing day. The report must indicate the minimum payment required under the terms of the policy to keep it in force and the length of the grace period for the payment of such amount.

Article XI - Foreign Companies

If the law or regulation in the place of domicile of a foreign company provides a degree of protection to the policyholders and the public which is substantially similar to that provided by these regulations, the Commission to the extent deemed appropriate by it in its discretion, may consider compliance with such law or regulation as compliance with these regulations.

Article XII - Qualifications of Agents for the Sale of Variable Life Insurance

Section 1. Qualification to Sell Variable Life Insurance.

a. No person may sell or offer for sale in this Commonwealth any variable life insurance policy unless such person is currently licensed by the Commission as a life and health insurance agent, is authorized to represent the insurer through which the policy is offered and evidence has been filed with the Commission, in a form satisfactory to the Commission, that such person also holds any license or authorization which may be required by this Commonwealth or the Federal Government for the solicitation or sale of variable life insurance.

b. Any examination administered by the Commission for the purpose of determining the eligibility of any person for licensing as an agent shall, after the effective date of this regulation, include such questions concerning the history, purpose, regulation, and sale of variable life insurance as the Commission deems appropriate.

Section 2. Reports of Disciplinary Actions.

Any person qualified in this Commonwealth under this Article to sell or offer to sell variable life insurance shall immediately report to the Commission:

a. Any suspension or revocation of his agent's license in any other state or territory of the United States;

b. The imposition of any disciplinary sanction, including suspension or expulsion from membership, suspension, or revocation of or denial of registration, imposed upon him by any national securities exchange, or national securities association, or any federal, state, or territorial agency with jurisdiction over securities or variable life insurance;

c. Any judgement or injuction entered against him on the basis of conduct deemed to have involved fraud, deceit, misrepresentation, or violation of any insurance or securities law or regulation.

Section 3. Refusal to Qualify Agent to Sell Variable Life Insurance: Suspension, Revocation, or Nonrenewal of Qualification.

The Commission may reject any application or suspend or revoke or refuse to renew any agent's qualification under this Article to sell or offer to sell variable life insurance upon any ground that would bar such applicant or such agent from being licensed to sell other life insurance contracts in this Commonwealth. The rules governing any proceeding relating to the suspension or

revocation of any agent's license shall also govern any preceeding for suspension or revocation of an agent's qualification to sell or to offer to sell variable life insurance.

Article XIII - Severability

If any provision of this regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of such provision to other persons or circumstances shall be not affected thereby.

STATE CORPORATION COMMISSION

AT RICHMOND, APRIL 30, 1992

COMMONWEALTH OF VIRGINIA

At the relation of the

STATE CORPORATION COMMISSION

CASE NO. INS920112

Ex Parte: In the matter of
adopting Revised Rules Governing
Minimum Standards for Medicare
Supplement Policies

ORDER SETTING HEARING

WHEREAS, Virginia Code § 12.1-13 provides that the Commission shall have the power to promulgate rules and regulations in the enforcement and administration of all laws within its jurisdiction and Virginia Code §§ 38.2-223, 38.2-514, 38.2-3516 through 38.2-3520, 38.2-3600 through 38.2-3609, 38.2-4214 and 38.2-4215 provide that the Commission is authorized to issue reasonable rules and regulations necessary to regulate minimum standards for medicare supplement insurance;

WHEREAS, the Bureau of Insurance has submitted to the Commission a proposed regulation entitled "Revised Rules Governing Minimum Standards for Medicare Supplement Policies"; and

WHEREAS, the Commission is of the opinion that a hearing should be held to consider the adoption of the proposed regulation;

THEREFORE, IT IS ORDERED:

(1) That the proposed regulation entitled "Revised Rules Governing Minimum Standards for Medicare Supplement Policies" be appended hereto and made a part hereof, filed and made a part of the record herein;

(2) That a hearing be held in the Commission's 3rd Floor Courtroom, Jefferson Building, Bank and Governor Streets, Richmond, Virginia at 10:00 a.m. on June 2, 1992, for the purpose of considering the adoption of the proposed revised regulation;

(3) That, on or before May 27, 1992, any person desiring to comment on the proposed regulation shall file such comments in writing with the Clerk of the Commission, Document Control Center, P.O. Box 2118, Richmond, Virginia 23216;

(4) That, in accordance with § 12.1-31 of the Code of Virginia, a Hearing Examiner shall conduct all further proceedings in this matter on behalf of the Commission, concluding with the filing of the Examiner's final report to the Commission. In the discharge of such duties, the Hearing Examiner shall exercise all the inquisitorial powers possessed by the Commission, including, but not limited to, the power to administer oaths, require the appearance of witnesses and parties and the production of documents, schedule and conduct rehearing conferences, admit or exclude evidence, grant or deny continuances, and rule on motions, matters of law, and procedural questions. Any party objecting to any ruling or action of said Examiner shall make known its objection with reasonable certainty at the time of the ruling, and may argue such objections to the Commission as part of its comments to the final report of said Examiner; provided, however, if any ruling by the Examiner denies further participation by any party in interest in a proceeding not thereby concluded, such party shall have the right to file a written motion with the Examiner for his immediate certification of such ruling to the Commission for its consideration. Pending resolution by the Commission of any ruling so certified, the Examiner shall retain procedural control of the proceeding;

(5) That the Hearing Examiner hereinbefore appointed shall cause the testimony taken at the hearing to be reduced to writing and promptly deliver his written findings and recommendations together with the transcript of the hearing to the Commission for its consideration and judgment;

(6) That an attested copy hereof, together with a copy of the proposed regulation, be sent by the Clerk of the Commission to the Bureau of Insurance in care of Deputy Commissioner, Gerald A. Milsky, who shall forthwith give further notice of the proposed revised regulation and hearing by mailing a copy of this order together with a copy of the proposed revised regulation to all companies licensed to write medicare supplement insurance in the Commonwealth of Virginia; and

(7) That the Bureau of Insurance shall file with the Clerk of the Commission an affidavit of compliance with the notice requirements of paragraph (6) above.

Rules Governing Minimum Standards for Medicare Supplement Policies (Insurance Regulation No. 35)

§ 1. Purpose.

The purpose of this regulation is to provide for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies; to facilitate public understanding and comparison of such policies; to eliminate provisions contained in such policies which may be misleading or confusing in connection with the purchase of such policies or with the settlement of claims; and to provide for full disclosures in the sale of accident and sickness insurance coverages to persons eligible for Medicare.

§ 2. Authority.

This regulation is issued pursuant to the authority vested in the Commission under §§ 38.2-223, 38.2-514, 38.2-3516 through 38.2-3520, 38.2-3600 through 38.2-3609, 38.2-4214, and 38.2-4215 of the Code of Virginia.

§ 3. Effective Date.

This regulation shall be effective on July 30, 1992.

§ 4. Applicability and Scope.

A. Except as otherwise specifically provided in Sections 8, 12, 13 and 21, this regulation shall apply to:

(1) All Medicare supplement policies delivered or issued for delivery in this Commonwealth on or after the effective date hereof, and

(2) All certificates issued under group Medicare supplement policies which certificates have been delivered or issued for delivery in this Commonwealth.

B. This regulation shall not apply to a policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

§ 5. Definitions.

For purposes of this regulation:

A. "Applicant" means:

(1) In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits, and

(2) In the case of a group Medicare supplement policy, the proposed certificateholder.

B. "Certificate" means any certificate delivered or issued for delivery in this Commonwealth under a group Medicare supplement policy.

C. "Certificate Form" means the form on which the certificate is delivered or issued for delivery by the issuer.

D. "Issuer" includes insurance companies, fraternal benefit societies, health service plans, health maintenance organizations, and any other entity delivering or issuing for delivery in this Commonwealth Medicare supplement policies or certificates.

E. "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

F. "Medicare Supplement Policy" means a group or individual policy of accident and sickness insurance or a subscriber contract of health service plans or health maintenance organizations, other than a policy issued pursuant to a contract under Section 1876 or Section 1833 of the federal Social Security Act (42 U.S.C. Section 1395 et. seq.) or an issued policy under a demonstration project authorized pursuant to amendments to the federal Social Security Act, which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare.

G. "Policy Form" means the form on which the policy is delivered or issued for delivery by the issuer.

§ 6. Policy Definitions and Terms.

No policy or certificate may be advertised, solicited or issued for delivery in this Commonwealth as a Medicare supplement policy or certificate unless such policy or certificate contains definitions or terms which conform to the requirements of this section.

A. "Accident," "Accidental Injury," or "Accidental Means" shall be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

(1) The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."

(2) Such definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

B. "Benefit Period" or "Medicare Benefit Period" shall not be defined more restrictively than as defined in the Medicare program.

C. "Convalescent Nursing Home," "Extended Care Facility," or "Skilled Nursing Facility" shall not be defined more restrictively than as defined in the Medicare program.

D. "Health Care Expenses" means expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers.

Such expenses shall not include:

(1) Home office and overhead costs;

(2) Advertising costs;

(3) Commissions and other acquisition costs;

(4) Taxes;

(5) Capital costs;

(6) Administrative costs; and

(7) Claims processing costs.

E. "Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals, but not more restrictively than as defined in the Medicare program.

F. "Medicare" shall be defined in the policy and certificate. Medicare may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly Known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

G. "Medicare Eligible Expenses" shall mean expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

H. "Physician" shall not be defined more restrictively than as defined in the Medicare program.

I. "Sickness" shall not be defined to be more restrictive than the following:

"Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force."

The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

§ 7. Policy Provisions.

A. Except for permitted preexisting condition clauses as described in Section 8A(1) and Section 9A(1) of this regulation, no policy or certificate may be advertised, solicited or issued for delivery in this Commonwealth as a Medicare supplement policy if such policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

B. No Medicare supplement policy or certificate may use waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

C. No Medicare supplement policy or certificate in force in the Commonwealth shall contain benefits which duplicate benefits provided by Medicare.

§ 8. Minimum Benefit Standards for Policies or Certificates Issued for Delivery Prior to July 30, 1992.

No policy or certificate may be advertised, solicited or issued for delivery in this Commonwealth as a Medicare supplement policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

A. General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

(1) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

(2) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(3) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes.

(4) A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" Medicare supplement policy shall not:

(a) Provide for termination of coverage of a spouse

solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or

(b) Be cancelled or nonrenewed by the issuer solely on the grounds of deterioration of health.

(5)

(a) Except as authorized by the Commission, an issuer shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

(b) If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in Paragraph (5)(d), the issuer shall offer certificateholders an individual Medicare supplement policy. The issuer shall offer the certificateholder at least the following choices:

(i) An individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy; and

(ii) An individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in Section 8B of this regulation.

(c) If membership in a group is terminated, the issuer shall:

(i) Offer the certificateholder such conversion opportunities as are described in Subparagraph (b); or

(ii) At the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

(d) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the succeeding issuer shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(6) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits.

B. Minimum Benefit Standards.

(1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

(2) Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;

(3) Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;

(4) Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of ninety percent (90%) of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;

(5) Coverage under Medicare Part A for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Part B;

(6) Coverage for the coinsurance amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible [$100];

(7) Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations or already paid for under Part A, subject to the Medicare deductible amount.

§ 9. Benefit Standards for Policies or Certificates Issued or Delivered on or After July 30, 1992.

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this Commonwealth on or after July 30, 1992. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this Commonwealth as a Medicare supplement policy or certificate unless it complies with these benefit standards.

A. General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

(1) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition.

The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

(2) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(3) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes provided that loss ratios are being met.

(4) No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

(5) Each Medicare supplement policy shall be guaranteed renewable and

(a) The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual; and

(b) The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

(c) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under Section 9A(5)(e), the issuer shall offer certificateholders an individual Medicare supplement policy which (at the option of the certificateholder)

(i) Provides for continuation of the benefits contained in the group policy, or

(ii) Provides for such benefits as otherwise meets the requirements of this subsection.

(d) If an individual is a certificateholder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall

(i) Offer the certificateholder the conversion opportunity described in Section 9A(5)(c), or

(ii) At the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

(e) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the succeeding issuer shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(6) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits.

(7)

(a) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate-holder for the period (not to exceed twenty-four (24) months) in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificateholder notifies the issuer of such policy or certificate within ninety (90) days after the date the individual becomes entitled to such assistance. Upon receipt of timely notice, the issuer shall return to the policyholder or certificateholder that portion of the premium attributable to the period of Medicaid eligibility, subject to adjustment for paid claims.

(b) If such suspension occurs and if the policyholder or certificate-holder loses entitlement to such medical assistance, such policy or certificate shall be automatically reinstituted (effective as of the date of termination of such entitlement) as of the termination of such entitlement if the policyholder or certificateholder provides notice of loss of such entitlement within ninety (90) days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of such entitlement.

(c) Reinstitution of such coverages:

(i) Shall not provide for any waiting period with respect to treatment of preexisting conditions;

(ii) Shall provide for coverage which is substantially equivalent to coverage in effect before the date of such suspension; and

(iii) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms

that would have applied to the policyholder or certificateholder had the coverage not been suspended.

(8) Coverage must be offered in compliance with +38.2-3418.1 however, information must accompany the offer stating that the coverage duplicates Medicare coverage and should not be purchased.

B. Standards for Basic ("Core") Benefits Common to All Benefit Plans

Every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic "core" package, but not in lieu thereof.

(1) Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

(2) Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

(3) Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of the Medicare Part A eligible expenses for hospitalization paid at the Diagnostic Related Group (DRG) day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days;

(4) Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

(5) Coverage for the coinsurance amount of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible;

C. Standards for Additional Benefits. The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by Section 10 of this regulation.

(1) Medicare Part A Deductible: Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

(2) Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A.

(3) Medicare Part B Deductible: Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(4) Eighty Percent (80%) of the Medicare Part B Excess Charges: Coverage for eighty percent (80%) of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(5) One Hundred Percent (100%) of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(6) Basic Outpatient Prescription Drug Benefit: Coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar ($250) calendar year deductible, to a maximum of one thousand two hundred fifty dollars ($1,250) in benefits received by the insured per calendar year, to the extent not covered by Medicare.

(7) Extended Outpatient Prescription Drug Benefit: Coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar ($250) calendar year deductible to a maximum of three thousand dollars ($3,000) in benefits received by the insured per calendar year, to the extent not covered by Medicare.

(8) Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars ($250), and a lifetime maximum benefit of fifty thousand dollars ($50,000). For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

(9) Preventive Medical Care Benefit: Coverage for the following preventive health services:

(a) An annual clinical preventive medical history and physical examination that may include tests and services from Subparagraph (b) and patient education to address preventive health care measures.

(b) Any one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

(1) Fecal occult blood test and/or digital rectal examination;

(2) Mammogram;

(3) Dipstick urinalysis for hematuria, bacteriuria and proteinuria;

(4) Pure tone (air only) hearing screening test, administered or ordered by a physician;

(5) Serum cholesterol screening (every five (5) years);

(6) Thyroid function test;

(7) Diabetes screening.

(c) Influenza vaccine administered at any appropriate time during the year and Tetanus and Diphtheria booster (every ten (10) years).

(d) Any other tests or preventive measures determined appropriate by the attending physician. Reimbursement shall be for the actual charges up to one hundred percent (100%) of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of one hundred twenty dollars ($120) annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

(10) At-Home Recovery Benefit: Coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.

(a) For purposes of this benefit, the following definitions shall apply:

(i) "Activities of daily living" include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self- administered, and changing bandages or other dressings.

(ii) "Care provider" means a duly qualified or licensed home health aide/homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

(iii) "Home" shall mean any place used by the insured as a place of residence, provided that such place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.

(iv) "At-home recovery visit" means the period of a visit required to provide at home recovery care, without limit on the duration of the visit, except each consecutive 4 hours in a 24-hour period of services provided by a care provider is one visit.

(b) Coverage Requirements and Limitations

(i) At-home recovery services provided must be primarily services which assist in activities of daily living.

(ii) The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

(iii) Coverage is limited to:

(I) No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment;

(II) The actual charges for each visit up to a maximum reimbursement of forty dollars ($40) per visit;

(III) One thousand six hundred dollars ($1,600) per calendar year;

(IV) Seven (7) visits in any one week;

(V) Care furnished on a visiting basis in the insured's home;

(VI) Services provided by a care provider as defined in this section;

(VII) At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded;

(VIII) At-home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than eight (8) weeks after the service date of the last Medicare approved home health care visit.

(c) Coverage is excluded for:

(i) Home care visits paid for by Medicare or other government programs; and

(ii) Care provided by family members, unpaid volunteers or providers who are not care providers.

(11) New or Innovative Benefits: An issuer may, with the prior approval of the Commission, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. Such new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies.

§ 10. Standard Medicare Supplement Benefit Plans.

A. An issuer shall make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic "core" benefits, as defined in Section 9B of this regulation.

B. No groups, packages or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted in Section 9C(11) of this regulation.

C. Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans "A" through "J" listed in this subsection and conform to the definitions in Section 5 of this regulation. Each benefit shall be structured in accordance with the format provided in Sections 9B and 9C and list the benefits in the order shown in this subsection. For purposes of this section, "structure, language, and format" means style, arrangement and overall content of a benefit.

D. An issuer may use, in addition to the benefit plan designations required in subsection C, other designations to the extent permitted by law.

E. Make-up of benefit plans:

(1) Standardized Medicare supplement benefit plan "A" shall be limited to the Basic ("Core") Benefits Common to All Benefit Plans, as defined in Section 9B of this regulation.

(2) Standardized Medicare supplement benefit plan "B" shall include only the following: The Core Benefit as defined in Section 9B of this regulation, plus the Medicare Part A Deductible as defined in Section 9C(1).

(3) Standardized Medicare supplement benefit plan "C" shall include only the following: The Core Benefit as defined in Section 9B of this regulation, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible and Medically Necessary Emergency Care in a Foreign Country as defined in Sections 9C(1), (2), (3) and (8) respectively.

(4) Standardized Medicare supplement benefit plan "D" shall include only the following: The Core Benefit (as defined in Section 9B of this regulation), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in an Foreign Country and the At-Home Recovery Benefit as defined in Sections 9C(1), (2), (8) and (10) respectively.

(5) Standardized Medicare supplement benefit plan "E" shall include only the following: The Core Benefit as defined in Section 9B of this regulation, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in a Foreign Country and Preventive Medical Care as defined in Sections 9C(1), (2), (8) and (9) respectively.

(6) Standardized Medicare supplement benefit plan "F" shall include only the following: The Core Benefit as defined in Section 9B of this regulation, plus the Medicare Part A Deductible, the Skilled Nursing Facility Care, the Part B Deductible, One Hundred Percent (100%) of the Medicare Part B Excess Charges, and Medically Necessary Emergency Care in a Foreign Country as defined in Sections 9C(1), (2), (3), (5) and (8) respectively.

(7) Standardized Medicare supplement benefit plan "G" shall include only the following: The Core Benefit as defined in Section 9B of this regulation, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Eighty Percent (80%) of the Medicare Part B Excess Charges, Medically Necessary Emergency Care in a Foreign Country, and the At-Home Recovery Benefit as defined in Sections 9C(1), (2), (4), (8) and (10) respectively.

(8) Standardized Medicare supplement benefit plan "H" shall consist of only the following: The Core Benefit as defined in Section 9B of this regulation, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Basic Prescription Drug Benefit and Medically Necessary Emergency Care in a Foreign Country as defined in Sections 9C(1), (2), (6) and (8) respectively.

(9) Standardized Medicare supplement benefit plan "I" shall consist of only the following: The Core Benefit as defined in Section 9B of this regulation, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, One Hundred Percent (100%) of the Medicare Part B Excess Charges, Basic Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country and At-Home Recovery Benefit as defined in Sections 9C(1), (2), (5), (6), (8) and (10) respectively.

(10) Standardized Medicare supplement benefit plan

"J" shall consist of only the following: The Core Benefit as defined in Section 9B of this regulation, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible, One Hundred Percent (100%) of the Medicare Part B Excess Charges, Extended Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country, Preventive Medical Care and At-Home Recovery Benefit as defined in Sections 9C(1), (2), (3), (5), (7), (8), (9) and (10) respectively.

§ 11. Open Enrollment.

A. No issuer shall deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this Commonwealth, nor discriminate in the pricing of such a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant where an application for such policy or certificate is submitted during the six (6) month period beginning with the first month in which an individual (who is 65 years of age or older) first enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an insurer shall be made available to all applicants who qualify under this subsection without regard to age.

B. Subsection A shall not be construed as preventing the exclusion of benefits under a policy, during the first six (6) months, based on a preexisting condition for which the policyholder or certificateholder received treatment or was otherwise diagnosed during the six (6) months before it became effective.

§ 12. Standards for Claims Payment.

A. An issuer shall comply with section 1882(c)(3) of the Social Security Act (as enacted by section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987, Pub. L. No. 100-203) by:

(1) Accepting a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;

(2) Notifying the participating physician or supplier and the beneficiary of the payment determination;

(3) Paying the participating physician or supplier directly;

(4) Furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number and a central mailing address to which notices from a Medicare carrier may be sent;

(5) Paying user fees for claim notices that are transmitted electronically or otherwise; and

(6) Providing to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

B. Compliance with the requirements set forth in Subsection A above shall be certified on the Medicare supplement insurance experience reporting form.

§ 13. Loss Ratio Standards and Refund or Credit of Premium.

A. Loss Ratio Standards

(1) Medicare Supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificate holders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form:

(a) At least seventy-five percent (75%) of the aggregate amount of premiums earned in the case of group policies, or

(b) At least sixty-five percent (65%) of the aggregate amount of premiums earned in the case of individual policies, calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for such period and in accordance with accepted actuarial principles and practices.

(2) All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

B. Refund or Credit Calculation

(1) An issuer shall collect and file with the Commission by May 31 of each year the data contained in the reporting form contained in Appendix A for each type in a standard Medicare supplement benefit plan.

(2) If on the basis of the experience as reported the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis

for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

(3) A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. Such refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary of Health and Human Services, but in no event shall it be less than the average rate of interest for 13-week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

C. Annual filing of Premium Rates.

An issuer of Medicare supplement policies and certificates issued before or after the effective date of this regulation in this Commonwealth shall file annually its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the Commission in accordance with the filing requirements and procedures prescribed by the Commission. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. Such demonstration shall exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three (3) years.

As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this Commonwealth shall file with the Commission, in accordance with the applicable filing procedures of this Commonwealth:

(1) (a) Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. Such supporting documents as necessary to justify the adjustment shall accompany the filing.

(b) An issuer shall make such premium adjustments as are necessary to produce an expected loss ratio under such policy or certificate as will conform with minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for such Medicare supplement policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein shall be made with respect to a policy at any time other than upon its renewal date or anniversary date.

(c) If an issuer fails to make premium adjustments acceptable to the Commission, the Commission may order premium adjustments, refunds or premium credits deemed necessary to achieve the loss ratio required by this section.

(2) Any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. Such riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

D. Public Hearings

The Commission may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of this regulation if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for such reporting period. Public notice of such hearing shall be furnished in a manner deemed appropriate by the Commission.

§ 14. Filing and Approval of Policies and Certificates and Premium Rates.

A. An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this Commonwealth unless the policy form or certificate form has been filed with and approved by the Commission in accordance with filing requirements and procedures prescribed by the Commission.

B. An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed with and approved by the Commission in accordance with the filing requirements and procedures prescribed by the Commission.

C.

(1) Except as provided in Paragraph (2) of this subsection, an issuer shall not file for approval more than one form of a policy or certificate of each type for each standard Medicare supplement benefit plan.

(2) An issuer may offer, with the approval of the Commission, up to four (4) additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one for

each of the following cases:

(a) The inclusion of new or innovative benefits;

(b) The addition of either direct response or agent marketing methods;

(c) The addition of either guaranteed issue or underwritten coverage;

(d) The offering of coverage to individuals eligible for Medicare by reason of disability.

(3) For the purposes of this section, a "type" means an individual policy or a group policy.

D.

(1) Except as provided in Paragraph (1)(a), an issuer shall continue to make available for purchase any policy form or certificate form issued after the effective date of this regulation that has been approved by the Commission. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve (12) months.

(a) An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the Commission in writing its decision at least thirty (30) days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the Commission, the issuer shall no longer offer for sale the policy form or certificate form in this Commonwealth.

(b) An issuer that discontinues the availability of a policy form or certificate form pursuant to Subparagraph (a) shall not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five (5) years after the issuer provides notice to the Commission of the discontinuance. The period of discontinuance may be reduced if the Commission determines that a shorter period is appropriate.

(2) The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this subsection.

(3) A change in the rating structure or methodology shall be considered a discontinuance under Paragraph (1) unless the issuer complies with the following requirements:

(a) The issuer provides an actuarial memorandum, in a form and manner prescribed by the commissioner, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and resultant rates.

(b) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The Commission may approve a change to the differential which is in the public interest.

E.

(1) Except as provided in Paragraph (2), the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in Section 13 of this regulation.

(2) Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

§ 15. Permitted Compensation Arrangements.

A. An issuer or other entity may provide commission or other compensation to an agent or other representative for the sale of a Medicare supplement policy or certificate only if the first year commission or other first year compensation is no more than two hundred percent (200%) of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

B. The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for no fewer than five (5) renewal years.

C. No issuer or other entity shall provide compensation to its agents or other producers and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.

D. For purposes of this section, "compensation" includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including but not limited to bonuses, gifts, prizes, awards and finders fees.

§ 16. Required Disclosure Provisions.

A. General Rules.

(1) Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of such provision shall be consistent with the type of contract issued. Such

provision shall be appropriately captioned and shall appear on the first page of the policy, and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

(2) Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy.

(3) Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import.

(4) If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations."

(5) Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificateholder shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have all premiums made for the policy refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

(6) Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis, other than incidentally, to a person(s) eligible for Medicare by reason of age shall provide to such applicants a Medicare Supplement Buyer's Guide in the form developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration and in a type size no smaller than 12 point type. Delivery of the Buyer's Guide shall be made whether or not such policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this regulation. Except in the case of direct response issuers, delivery of the Buyer's Guide shall be made to the applicant at the time of application and acknowledgement of receipt of the Buyer's Guide shall be obtained by the issuer. Direct response issuers shall deliver the Buyer's Guide to the applicant upon request but not later than at the time the policy is delivered.

B. Notice Requirements.

(1) As soon as practicable, but no later than thirty (30) days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificateholders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the Commission. Such notice shall:

(a) Include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate, and

(b) Inform each policyholder or certificateholder as to when any premium adjustment is to be made due to changes in Medicare.

(2) The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension.

(3) Such notices shall not contain or be accompanied by any solicitation.

C. Outline of Coverage Requirements for Medicare Supplement Policies.

(1) Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgement of receipt of such outline from the applicant; and

(2) If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany such policy or certificate when it is delivered and contain the following statement, in no less than twelve (12) point type, immediately above the company name:

"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

(3) The outline of coverage provided to applicants pursuant to this section consists of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed below in no less than twelve (12) point type. All plans A-J shall be shown on the cover page, and the plan(s) that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

(4) The following items shall be included in the outline of coverage in the order prescribed below.

[COMPANY NAME]
Outline of Medicare Supplement Coverage–Cover Page:
Benefit Plan(s) _____ [insert letter(s) of plans(s) being offered]

Medicare supplement insurance can be sold in only ten standard plans. This chart shows the benefits included in each plan.
Every company must make available Plan "A". Some plans may not be available in your state.

BASIC BENEFITS: Included in all Plans.
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (20% of Medicare–approved expenses).
Blood: First three pints of blood each year.

A	B	C	D	E	F	G	H	I	J
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Co–Insurance	Skilled Nursing Co–Insurance	Skilled Nursing Co–Insurance	Skilled Nursing Co–Insurance	Skilled Nursing Co–Insurance	Skilled Nursing Co–Insurance	Skilled Nursing Co–Insurance	Skilled Nursing Co–Insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At–Home Recovery			At–Home Recovery		At–Home Recovery	At–Home Recovery
							Basic Drugs ($1,250 Limit)	Basic Drugs ($1,250 Limit)	Extended Drugs ($3,000 Limit)
				Preventive Care					Preventive Care

PREMIUM INFORMATION [Boldface Type]

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this State. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]

DISCLOSURES [Boldface Type]

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY [Boldface Type]

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT [Boldface Type]

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE [Boldface Type]

This policy may not fully cover all of your medical costs.

[for agents:]
Neither [insert company's name] nor its agents are connected with Medicare.

[for direct response:]
[insert company's name] is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "The Medicare Handbook" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts pursuant to Section 10D of this regulation.]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the Commission.]

PLAN A

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $652	$0	$652 (Part A Deductible)
61st thru 90th day	All but $163 a day	$163 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $326 a day	$326 a day	$0
– Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
– Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $81.50 a day	$0	Up to $81.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN A

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $100 of Medicare–Approved amounts for covered services (which are noted with an asterik), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
–Medically necessary skilled care services and medical supplies	100%	$0	$0
–Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN B

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $652	$652 (Part A Deductible)	$0
61st thru 90th day	All but $163 a day	$163 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $326 a day	$326 a day	$0
– Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
– Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare–approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $81.50 a day	$0	Up to $81.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN B

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $100 of Medicare–Approved amounts for covered services (which are noted with an asterik), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN C

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $652	$652 (Part A Deductible)	$0
61st thru 90th day	All but $163 a day	$163 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $326 a day	$326 a day	$0
– Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
– Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare–approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $81.50 a day	Up to $81.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN C

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $100 of Medicare–Approved amounts for covered services (which are noted with an asterik, your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
–Medically necessary skilled care services and medical supplies	100%	$0	$0
–Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
Medically necessary emergency care service beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN D

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $652	$652 (Part A Deductible)	$0
61st thru 90th day	All but $163 a day	$163 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $326 a day	$326 a day	$0
– Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
– Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare–approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $81.50 a day	Up to $81.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN D (continued)

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES – Medically necessary skilled care services and medical supplies – Durable medical equipment First $100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% $0 80%	$0 $0 20%	$0 $100 (Part B Deductible) $0
AT–HOME RECOVERY SERVICES – NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan – Benefit for each visit – Number of visits covered (must be received within 8 weeks of last Medicare Approved visit) – Calendar year maximum	$0 $0 $0	Actual Charge to $40 a visit Up to the number of Medicare Approved visits, not to exceed 7 each week $1,600	Balance

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of Charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000	 $250 20% and amounts over the $50,000 lifetime maximum

PLAN D

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $100 of Medicare–Approved amounts for covered services (which are noted with an asterik), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First $100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	 $0 80% $0	 $0 20% $0	 $100 (Part B Deductible) $0 All Costs
BLOOD First 3 pints Next $100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	$0 $0 80%	All Costs $0 20%	$0 $100 (Part B Deductible) $0
CLINICAL LABORATORY SERVICES – BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN E

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $652	$652 (Part A Deductible)	$0
61st thru 90th day	All but $163 a day	$163 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $326 a day	$326 a day	$0
– Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
– Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $81.50 a day	Up to $81.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

PLAN E

MEDICARE (PART B) – MEDICAL SERVICES – PER CLAENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterik, your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
–Medically necessary skilled care services and medical supplies	100%	$0	$0
–Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

(continued)

PLAN E (continued)

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
PREVENTIVE MEDICAL CARE BENEFIT–NOT COVERED BY MEDICARE Annual physical and preventive tests and services such as: fecal occult blood tests, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diptheria booster and education, administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All Costs

PLAN F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $652	$652 (Part A Deductible)	$0
61st thru 90th day	All but $163 a day	$163 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $326 a day	$326 a day	$0
– Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
– Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $81.50 a day	Up to $81.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN F

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $100 of Medicare–Approved amounts for covered services (which are noted with an asterik), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
–Medically necessary skilled care services and medical supplies	100%	$0	$0
–Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $652	$652 (Part A Deductible)	$0
61st thru 90th day	All but $163 a day	$163 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $326 a day	$326 a day	$0
– Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
– Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare–approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $81.50 a day	Up to $81.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN G

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $100 of Medicare–Approved amounts for covered services (which are noted with an asterik), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	80%	20%
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN G (continued)

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
–Medically necessary skilled care services and medical supplies	100%	$0	$0
–Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
AT–HOME RECOVERY SERVICES – NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
– Benefit for each visit	$0	Actual Charge to $40 a visit	Balance
– Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
– Calendar year maximum	$0	$1,600	

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN H

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $652	$652 (Part A Deductible)	$0
61st thru 90th day	All but $163 a day	$163 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $326 a day	$326 a day	$0
– Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
– Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $81.50 a day	Up to $81.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN H

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterik), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
–Medically necessary skilled care services and medical supplies	100%	$0	$0
–Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

(continued)

PLAN I

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $652	$652 (Part A Deductible)	$0
61st thru 90th day	All but $163 a day	$163 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $326 a day	$326 a day	$0
– Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
– Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $81.50 a day	Up to $81.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN H (continued)

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS – NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $2,500 each calendar year	$0	50% – $1,250 calendar year maximum benefit	50%
Over $2,500 each calendar year	$0	$0	All Costs

PLAN I

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $100 of Medicare–Approved amounts for covered services (which are noted with an asterik), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN I (continued)

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
–Medically necessary skilled care services and medical supplies	100%	$0	$0
–Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
AT–HOME RECOVERY SERVICES – NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
– Benefit for each visit	$0	Actual Charge to $40 a visit	Balance
– Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
– Calendar year maximum		$1,600	

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care service beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges*	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS – NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $2,500 each calendar year	$0	50% – $1,250 calendar year maximum benefit	50%
Over $2,500 each calendar year	$0	$0	All Costs

PLAN J

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $652	$652 (Part A Deductible)	$0
61st thru 90th day	All but $163 a day	$163 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $326 a day	$326 a day	$0
– Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
– Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare–approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $81.50 a day	Up to $81.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN J

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $100 of Medicare–Approved amounts for covered services (which are noted with an asterik), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
–Medically necessary skilled care services and medical supplies	100%	$0	$0
–Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

(continued)

PLAN J (continued)

PARTS A & B (continued)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE (cont'd) AT-HOME RECOVERY SERVICES – NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care beginning during recovey from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
–Benefit for each visit	$0	Actual Charges to $40 a visit	Balance
–Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
–Calendar year maximum	$0	$1,600	

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care service beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
EXTENDED OUTPATIENT PRESCRIPTION DRUGS – NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $6,000 each calendar year	$0	50% – $3,000 calendar year maximum benefit	50%
Over $6,000 each calendar year	$0	$0	All Costs
PREVENTIVE MEDICAL CARE BENEFIT–NOT COVERED BY MEDICARE Annual physical and preventive tests and services such as: fecal occult blood tests, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diptheria booster and education, administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All Costs

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to terminate existing Medicare supplement insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy only if, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision.

STATEMENT TO APPLICANT BY ISSUER, AGENT [OR OTHER REPRESENTATIVE]:

I have reviewed your current medical or health insurance coverage. The replacement of insurance involved in this transaction does not duplicate coverage, to the best of my knowledge. The replacement policy is being purchased for the following reason(s) (check one):

___ Additional benefits.
___ No change in benefits, but lower premiums.
___ Fewer benefits and lower premiums.
___ Other. (please specify)

_____
_____
_____

1. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____
(Signature of Agent, or Other Representative)*

[Typed Name and Address of Issuer, or Agent]

_____
(Applicant's Signature)

_____
(Date)

*Signature not required for direct response sales.

D. Notice Regarding Policies or Certificates Which Are Not Medicare Supplement Policies.

Any accident and sickness insurance policy or certificate, other than a Medicare supplement policy; or a policy issued pursuant to a contract under Section 1876 or Section 1833 of the Federal Social Security Act (42 U.S.C. 1395 et seq.), disability income policy; basic, catastrophic, or major medical expense policy; single premium nonrenewable policy or other policy identified in Section 4.B of this regulation, issued for delivery in this Commonwealth to persons eligible for Medicare by reason of age shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. Such notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate delivered to insureds. Such notice shall be in no less than twelve (12) point type and shall contain the following language:

"THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the company."

§ 17. Requirements for Application Forms and Replacement Coverage.

A. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another Medicare supplement or other health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent containing such questions and statements may be used.

[Statements]

(1) You do not need more than one Medicare supplement policy.

(2) If you are 65 or older, you may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

(3) The benefits and premiums under your Medicare supplement policy will be suspended during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstituted if requested within 90 days of losing Medicaid eligibility.

(4) Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning Medicaid.

[Questions]

To the best of your knowledge,

(1) Do you have another Medicare supplement policy or certificate in force (including health care service contract, health maintenance organization contract)?

(a) If so, with which company?

(2) Do you have any other health insurance policies that provide benefits which this Medicare supplement policy would duplicate?

(a) If so, with which company?

(b) What kind of policy?

(3) If the answer to question 1 or 2 is yes, do you intend to replace these medical or health policies with this policy [certificate]?

(4) Are you covered by Medicaid?

B. Agents shall list any other health insurance policies they have sold to the applicant.

(1) List policies sold which are still in force.

(2) List policies sold in the past five (5) years which are no longer in force.

C. In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.

D. Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One copy of the notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage.

E. The notice required by Subsection D above for an issuer shall be provided in substantially the following form in no less than ten (10) point type:

Appendix A

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR

Type_____ SMSBP(w)_____
FOR THE STATE OF _____
Company Name_____
NAIC Group Code_____ NAIC Company Code_____
Address_____
Person Completing This Exhibit_____
Title_____ Telephone Number_____

line		(a) Earned Premium (x)	(b) Incurred Claims (y)
1	Current Year's Experience		
	a. Total (all policy years)		
	b. Current year's issues (z)		
	c. Net (for reporting purposes = 1a – 1b)		
2	Past Year's Experience (All Policy Years)		
3	Total Experience (Net Current Year + Past Year's Experience)		
4	Refund last year (Excluding Interest)		
5	Pevious Since Inception (Excluding interest)		
6	Refunds Since Inception (Excluding Interest)		
7	Benchmark Ratio Since Inception		
8	Experienced Ratio Since Inception		
	Total Actual Incurred Claims (line 3, col b) = Ratio 2 / Total Earned Prem. (line 3, col a) – Refunds Since Inception (line 6)		
9	Life Years Exposes Since Inception		

If the Experienced Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.

10 Tolerance Permitted (obtained rom credibility table)_____

§ 18. Filing Requirements for Advertising.

An issuer shall provide a copy of any Medicare supplement advertisement intended for use in this Commonwealth whether through written, radio or television medium to the Commission for review.

§ 19. Standards for Marketing.

A. An issuer, directly or through its producers, shall:

(1) Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.

(2) Establish marketing procedures to assure excessive insurance is not sold or issued.

(3) Display prominently by type, stamp or other appropriate means, on the first page of the policy the following:

"Notice to buyer: This policy may not cover all of your medical expenses."

(4) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance.

(5) Establish auditable procedures for verifying compliance with this Subsection A.

B. In addition to the practices prohibited in Chapter 5 of Title 38.2 §§ 38.2-500 et. seq.

(1) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.

(2) High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

(3) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

C. The terms "Medicare Supplement," "Medigap," "Medicare Wrap-Around" and words of similar import shall not be used unless the policy is issued in compliance with this regulation.

§ 20. Appropriateness of Recommended Purchase and Excessive Insurance.

A. In recommending the purchase or replacement of any Medicare supplement policy or certificate an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

B. Any sale of Medicare supplement coverage that will provide an individual more than one Medicare supplement policy or certificate is prohibited.

§ 21. Reporting of Multiple Policies.

A. On or before March 1 of each year, an issuer shall report in the format prescribed in Appendix B the following information for every individual resident of this Commonwealth for which the issuer has in force more than one Medicare supplement policy or certificate:

(1) Policy and certificate number, and

(2) Date of issuance.

B. The items set forth above must be grouped by individual policyholder.

§ 22. Prohibition Against Preexisting Conditions, Waiting Periods, Elimination Periods and Probationary Periods in Replacement Policies or Certificates.

A. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate to the extent such time was spent under the original policy.

B. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six (6) months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods.

§ 23. Severability.

If any provision of this regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of such provision to other persons or circumstances shall not be affected thereby.

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR

Type_____ SMSBP(w)_____
FOR THE STATE OF _____
Company Name_____
NAIC Group Code_____ NAIC Company Code_____
Address_____
Person Completing This Exhibit_____
Title_____ Telephone Number_____

11 Adjustment to Incurred Claims for Credibility

Ratio 3 = Ration 2 + Tolerance

If Ratio 3 is more than Benchmark ratio (ration 1), a refund or credit to premium is not required.

If Ratio 3 is less than the benchmark ratio, then proceed.

12 Adjusted Incurred Claims =

[Total Earned Premiums (line 3, col a)– Refunds Since Inception (Line 6)] X Ratio 3 (Line 11)

13 Refund = Total Earned Premiums (line 3, col a)– Refunds Since Inception (line6)

Adjusted Incurred Claims (line 12)

Benchmark Ration (Ratio 1)

If the amount on the line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund and/or credit against premiums to be used must be attached to this form.

Medicare Supplemetn Credibility Table

Life Years Exposed Since Inception	Tolerance
10,000 +	0.0%
5,000 – 9,999	5.0%
2,500 – 4,999	7.5%
1,000 – 2,499	10.0%
500–999	15.0%

If less than 500, no credibility.

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR

Type_____ SMSBP(w)_____
FOR THE STATE OF _____
Company Name_____
NAIC Group Code_____ NAIC Company Code_____
Address_____
Person Completing This Exhibit_____
Title_____ Telephone Number_____

(w) "SMSBP" = Standardized Medicare Supplement Benefit Plan
(x) Includes modal loadings and fees charged.
(y) Excludes Active Life Reserves.
(z) This is to be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratios"

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

_____
Signature

_____
Name – Please Type

_____
Title

_____
Date

REPORTING FROM FOR THE CALCULATION OF
BENCHMARK RATIO SINCE INCEPTION
FOR GROUP POLICIES
FOR CALENDAR YEAR _____

TYPE_____ SMSBP(p)_____
FOR THE STATE OF _____
Company Name_____
NAIC Group Code_____ NAIC Company Code_____
Address_____
Person Completing This Exhibit_____
Title_____ Telephone Number_____

(a) Year	(b) Earned Premium	(c) Factor	(d) (b) x (c)	(e) Cumulative Loss Ratio	(j) (d) x (e)	(g) Factor	(h) (b) x (g)	(i) Cumulative Loss Ratio	(j) (h) x (i)	(o) Policy Year Loss Ratio
1		2.770		0.507		0.000		0.000		0.46
2		4.175		0.567		0.000		0.000		0.63
3		4.175		0.567		1.194		0.759		0.75
4		4.175		0.567		2.245		0.771		0.77
5		4.175		0.567		3.170		0.782		0.8
6		4.175		0.567		3.998		0.792		0.82
7		4.175		0.567		4.754		0.802		0.84
8		4.175		0.567		5.445		0.811		0.87
9		4.175		0.567		6.075		0.818		0.88
10		4.175		0.567		6.650		0.824		0.88
11		4.175		0.567		7.176		0.828		0.88
12		4.175		0.567		7.655		0.831		0.88
13		4.175		0.567		8.093		0.834		0.89
14		4.175		0.567		8.493		0.837		0.89
15		4.175		0.567		8.684		0.838		0.89
Total:		(k):		(i):		(m):		(n):		

Benchmark Ration Since Inception: (l + n) / (k + m):

(a): Year 1 is the current calendar year – 1
Year 2 is the current calendar year – 2
(etc).
(Example: If the current year is 1991, then:
Year 1 is 1990, Year 2 is 1989, etc.)

(b): For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

(o): These loss ratios are not explictly used in computing the benchmark loss ratios. They are the los ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

(p): "SMSBP" = Standardized Medicare Supplemental Benefit Plan

REPORTING FROM FOR THE CALCULATION OF
BENCHMARK RATIO SINCE INCEPTION
FOR GROUP POLICIES
FOR CALENDAR YEAR _____

TYPE_____ SMSBP(p)_____
FOR THE STATE OF _____
Company Name_____
NAIC Group Code_____ NAIC Company Code_____
Address_____
Person Completing This Exhibit_____
Title_____ Telephone Number_____

(a) Year	(b) Earned Premium	(c) Factor	(d) (b) x (c)	(e) Cumulative Loss Ratio	(j) (d) x (e)	(g) Factor	(h) (b) x (g)	(i) Cumulative Loss Ratio	(j) (h) x (i)	(o) Policy Year Loss Ratio
1		2.770		0.442		0.000		0.000		0.4
2		4.175		0.493		0.000		0.000		0.55
3		4.175		0.493		1.194		0.659		0.65
4		4.175		0.493		2.245		0.669		0.67
5		4.175		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75
9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15		4.175		0.493		8.684		0.725		0.77
Total:		(k):		(i):		(m):		(n):		

Benchmark Ration Since Inception: (l + n) / (k + m):

(a): Year 1 is the current calendar year – 1
Year 2 is the current calendar year – 2
(etc).
(Example: If the current year is 1991, then:
Year 1 is 1990, Year 2 is 1989, etc.)

(b): For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

(o): These loss ratios are not explictly used in computing the benchmark loss ratios. They are the los ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

(p): "SMSBP" = Standardized Medicare Supplemental Benefit Plan

Appendix B

FORM FOR REPORTING
MEDICARE SUPPLEMENT POLICIES

Company Name_____

Address_____

_____

Phone Number_____

Due: March 1, annually

The purpose of this form is to report the following information on each resident of this state who has in force more than one Medicare supplement policy or certificate. The information is to be grouped by individual policyholder.

Policy and Certificate#	Date of Issuance

_____
Signature

_____
Name and Title (please type)

_____
Date

FINAL REGULATION

MARINE RESOURCES COMMISSION

NOTICE: The Marine Resources Commission is exempted from the Administrative Process Act (§ 9-6.14:4 of the Code of Virginia); however, it is required by § 9-6.14:22 B to publish all final regulations.

Title of Regulation: **VR 450-01-9203. Closure of All Public Oyster Grounds in the James River.**

Statutory Authority: §§ 28.1-82 and 28.1-85 of the Code of Virginia.

Effective Dates: June 1, 1992 to October 1, 1992.

Preamble:

The following order of the Marine Resources Commission closes all public oyster grounds in the James River to the taking of oysters.

VR 450-01-9203. Closure of All Public Oyster Grounds in the James River.

§ 1. Authority and effective date.

A. This order is promulgated pursuant to authority contained in §§ 28.1-82 and 28.1-85 of the Code of Virginia.

B. The effective date of this order is June 1, 1992.

§ 2. Purpose.

The purpose of this order is to close all public oyster grounds in the James River to the taking of oysters in order to protect and promote the oyster resource in the area.

§ 3. Closed area.

All public oyster grounds in the James River are hereby closed to the taking of oysters.

§ 4. Expiration date.

This order shall terminate on October 1, 1992.

/s/ William A. Pruitt
Commissioner
Date: April 30, 1992

EMERGENCY REGULATION

MARINE RESOURCES COMMISSION

Title of Regulation: **VR 450-01-0077. Pertaining to the Special Permit for Removal or Harvest of Relay Clams from Polluted Waters.**

Statutory Authority: § 28.1-25 of the Code of Virginia.

Effective Dates: May 1, 1992 to June 1, 1992

Preamble:

This regulation establishes the procedure for reliquishing and reclaiming the special permit issued for removal or harvest of relay clams from polluted waters. It restricts permitted clammers to work only polluted bottom, or turn in their permit and work only clean bottom.

VR 450-01-0077. Pertaining to the Special Permit for Removal or Harvest of Relay Clams from Polluted Waters.

§ 1. Authority, prior regulation, effective date, termination date.

A. This emergency regulation is promulgated pursuant to the authority contained in § 28.1-25 of the Code of Virginia.

B. Section 28.1-179 of the Code of Virginia specifies that it shall be unlawful for any person, firm, or corporation to take, catch, transport, sell, offer for sale, remove, receive, keep or store shellfish from condemned areas, or relay shellfish taken from such areas, until the Commission has issued a special permit which the permittee must carry when engaged in such operation.

C. The effective date of this regulation is May 1, 1992.

D. The regulation shall terminate on June 1, 1992.

§ 2. Purpose.

The purpose of this regulation is to prohibit clammers who possess special permits to remove or harvest relay clams from working in both polluted and clean waters. This possibility of mixing relay clams with clean clams will therefore be eliminated.

§ 3. Special permit restrictions.

A. It shall be unlawful for any person, firm or corporation who has been issued a special permit for relay clams as required by § 28.1-179 of the Code of Virginia, to remove or harvest clean clams without first relinquishing said permit to the VMRC Operations Office. Operations personnel will hold the special permit until such time when the clammer reclaims possession of it to harvest relay clams.

B. Special permits issued for the harvest of relay clams may be turned in or reclaimed at VMRC Operations, 30 Jefferson Avenue, Newport News between the hours of 9:00 A.M. and 4:00 P.M. on Monday through Friday, excluding State holidays.

§ 4. Penalty.

As set forth in § 28.1-23 of the Code of Virginia, any person violating any provision of this regulation shall be guilty of a Class 1 misdemeanor.

/s/ William A. Pruitt
Commissioner
Date: April 30. 1992

EXECUTIVE ORDER NUMBER FORTY-FOUR (92)

PROVIDING ASSISTANCE BY THE VIRGINIA ARMY NATIONAL GUARD TO THE COMMONWEALTH OF KENTUCKY IN FIGHTING FOREST FIRES FROM NOVEMBER 2 TO NOVEMBER 8, 1991.

Whereas the Governor of the Commonwealth of Kentucky, the Honorable Wallace G. Wilkinson, by Executive Order 91-1072, dated October 30, 1991, a copy of which is attached, called out the Kentucky National Guard to assist the Kentucky Divison of Forestry and the United States Forest Service in fighting forest fires in Kentucky during the period from October 29 through November 29, 1991;

Whereas, the Commonwealth of Kentucky lacked sufficient helicopters to cary all of the helicopter water buckets which were available and necessary to suppress the forest fires raging within Kentucky on and about November 1, 1991;

Whereas, Governor Wilkinson, by letter dated November 1, 1991, a copy of which is attached, requested that the Commonwealth of Virginia come to the aid of the Commonwealth of Kentucky pursuant to the National Guard Mutual Assistance Compact by sending three Army National Guard UH-60 Blackhawk helicopters with crews and maintenance support to assist the Commonwealth of Kentucky in fighting those forest fires;

Whereas, Governor Wilkinson, in his letter requesting assistance, committed the Commonwealth of Kentucky to pay all expenses associated with the effort and to abide by all provisions of the National Guard Mutual Assistance Compact;

Whereas, due to the emergency nature of the request and the lack of time available prior to departure of the requested helicopters and personnel for Kentucky, I verbally issued orders that the Adjutant General of Virginia dispatch the requested assistance to Kentucky as soon as flying conditions permitted under the terms set forth below herein;

Therefore, by virtue of the authority vested in me under Article V, Section 7 of the Constitution of Virginia, the provisions of Section 44-75.1 (4) of the Code of Virginia, and the National Guard Mutual Assistance Compact, Section 44-54.1 of the Code of Virginia, I do hereby confirm, ratify and memorialize in writing my verbal orders issued on November 1, 1991, wherein I directed the Adjutant General of Virginia to deploy three Army National Guard UH-60 Blackhawk helicopters, other ancillary National Guard equipment and National Guard flight crews and maintenance personnel to the Commonwealth of Kentucky, there to assist the Commonwealth of Kentucky in fighting forest fires for so long as needed or until recalled to Virginia, all pursuant to and in accordance with the National Guard Mutual Assistance Compact, Section 44-54.1 of the Code of Virginia.

In addition to the provisions of the National Guard Mutual Assistance Compact, the following conditions did and do continue to apply to said deployment of the Virginia National Guard:

1. Should service under this Executive Order result in the injury or death of any member of the Virginia National Guard, the following will be provided to the member and the member's dependents or survivors:

(a) Workers' Compensation benefits provided to members of the National Guard by the Virginia Workers' Compensation Act; and, in addition,

(b) The same benefits for injury, disability and/or death, or their equivalent, as would be provided by the federal government if the member were serving on federal active duty at the time of injury or death. Any such federal-type benefits due to a member and his/her dependents or survivors during any calendar month shall be reduced by any payments due under the Virginia Workers' Compensation Act during the same month. If and when the time period for payment of Workers' Compensation benefits has elapsed, the member and his/her dependents or survivors shall thereafter receive full federal-type benefits for as long as they would have received such benefits if the member had been serving on federal active duty at the time of the injury or death. Any federal-type benefits due shall be computed on the basis of military pay grade E-5 or the member's military grade at the time of the injury or death, whichever produces the greater benefit amount. Pursuant to Section 44-14 of the Code of Virginia, and subject to the concurrence of the Board of Military Affairs, I now approve of future expenditures out of appropriations to the Department of Military Affairs for such federal-type benefits as being manifestly for the benefit of the military service.

2. The cost incurred by the Virginia Department of Military Affairs in performing this mission shall be paid out of the sum sufficient appropriation for Disaster Planning and Operations contained in Item 728.3 of Chapter 723 of the 1991 Acts of the General Assembly. The reimbursement of such costs committed by the Governor of Kentucky on behalf of the Commonwealth of Kentucky shall be paid into the Treasury of the Commonwealth of Virginia to defray said sum sufficient expenditures when received.

This Executive Order will become retroactively effective on November 1, 1991, upon its signing, and, except for that portion providing for benefits in the event of injury or death, retroactively ceased to be in effect on midnight, November 8, 1991, when all helicopters and personnel had returned from duty in the Commonwealth of Kentucky.

Given under my hand and under the Seal of the Commonwealth of Virginia this 27th day of April, 1992.

/s/ Lawrence Douglas Wilder
Governor

GOVERNOR WALLACE G. WILKINSON
CAPITOL
FRANKFORT, KENTUCKY 40601

November 1, 1991

Governor L. Douglas Wilder
State Capitol
Richmond, Virginia 23219

Dear Governor Wilder:

Pursuant to the National Guard Mutual Assistance Compact to which Kentucky is a part, I GOVERNOR WALLACE G. WILKINSON, Governor of Kentucky, request the State of Virginia to provide emergency military support to the state of Kentucky for the purpose of fighting forest fires.

We urgently need three Army Guard UH 60 Black Hawk Helicopters with crew and maintenance support to assist us with this effort. We agree to pay all expenses associated with this effort. We also further agree to abide by all provisions of this compact.

Sincerely,

Wallace G. Wilkinson

EXECUTIVE ORDER NUMBER FORTY-FIVE (92)

DECLARATION OF STATE OF EMERGENCY ARISING FROM FLASH FLOODING IN THE WESTERN REGION OF VIRGINIA

On April 21, 1992, extremely heavy rains occurred in an area starting in Southwest Virginia and continuing up through Roanoke Valley, the Upper Shenandoah Valley and other affected areas of the state. These rains resulted in flash floods which caused roads and bridges to be washed out, resulted in considerable public and private property damage, and contributed to the loss of at least one life.

The health and general welfare of the citizens of the localities affected required that state action be taken to help alleviate the conditions which were a result of this situation. This constituted an emergency as contemplated under the provisions of Section 44-146.16 of the Code of Virginia. I also found that these flash floods constitued a disaster wherein life could be imperiled and personal injuries were threatened and significant damage to public and private property had occurred.

Therefore, by virtue of the authority vested in me by Section 44-146.17 of the Code of Virginia, as Governor and as Director of Emergency Services, and by virtue of the authority vested in me by Article V, Section 7 of the Constitution of Virginia and by Section 44-75.1 of the Code of Virginia, as Governor and Commander-in-Chief of the armed forces of the Commonwealth, and subject to my continuing and ultimate authority and responsibility to act in such matters, I do hereby confirm, ratify and memorialize in writing my verbal proclamation on April 24, 1992, that a state of emergency existed in the affected areas of the Commonwealth and I directed that appropriate assistance be rendered by the agencies of the state and local governments to alleviate these conditions. Pursuant to Section 44-75.1 (3) and (4) of the Code of Virginia, I also directed that the Virginia National Guard be called forth to assist in providing such aid, as may be required by the Coordinator of the Department of Emergency Services, in consultation with the Adjutant General of Virginia and with the approval of the Secretary of Public Safety.

The following conditions did and do continue to apply to the employment of the Virginia National Guard:

1. The Adjutant General of Virginia, after consultation with the State Coordinator of Emergency Services and with the approval of the Secretary of Public Safety, shall make available on state active duty such units and members of the Virginia National Guard and such equipment as may be desirable to assist in alleviating the human suffering and damage to property as a result of flash flooding.

2. In all instances, members of the Virginia National Guard shall remain subject to military command as prescribed by Section 44-78.1 of the Code of Virginia and not subject to the civilian authorities of the state or local governments.

3. Should service under this Executive Order result in the injury or death of any member of the Virginia National Guard, the following will be provided to the member and the member's dependents or survivors:

(a) Workers' Compensation benefits provided to members of the National Guard by the Virginia Workers' Compensation Act; and, in addition,

(b) The same benefits, or their equivalent, for injury, disability, and/or death, as would be provided by the federal government if the member were serving on federal active duty at the time of the injury or death. Any such federal-type benefits due to a member and his or her dependents or survivors during any calendar month shall be reduced by any payments due under the Virginia Workers' Compensation Act during the same month. If and when the time period for payment of Workers' Compensation benefits has elapsed, the member and his or her dependents or survivors shall thereafter receive full federal-type benefits for as long as they would have received such benefits if the member had been serving on federal active duty at the time of injury or death. Any federal-type benefits due shall be computed on the basis of military pay grade E-5 or the member's military grade at the time of injury or death, whichever produces the greater benefit amount. Pursuant to Section 44-14 of the Code of Virginia, and subject to the concurrence of the Board of Military Affairs, I now approve future expenditures out of appropriations to the Department of Military Affairs for such federal-type benefits as being manifestly for the benefit of the military service.

4. The cost incurred by the Department of Military Affiars in performing this mission shall be paid out of the sum sufficient appropriation for Disaster Planning and Operations contained in Item 728.3 of Chapter 723 of the 1991 Acts of Assembly.

This Executive Order shall become retroactively effective April 24, 1992, upon its signing, and shall remain in full force and effect until June 30, 1992, unless sooner amended or rescinded by further executive order. That portion providing for benefits for members of the National Guard in the event of injury or death shall continue to remain in effect after termination of the Executive Order as a whole.

Given under my hand and under the Seal of the Commonwealth of Virginia, this 27th day of April 1992.

/s/ Lawrence D. Wilder
Governor

GOVERNOR'S COMMENTS ON PROPOSED

REGULATIONS

(Required by § 9-6.12:9.1 of the Code of Virginia)

DEPARTMENT OF AVIATION (BOARD OF)

Title of Regulation: **VR 165-01-02:1. Regulations Governing the Licensing and Operation of Airports and Aircraft and Obstructions to Airspace in the Commonwealth of Virginia**

Governor's Comment:

This regulation will repeal and replace existing rules pertaining to the licensing and operation of airports and aircraft. I recommend approval.

/s/ Lawrence Douglas Wilder
Governor
Date: May 11, 1992

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Title of Regulation: **VR 460-02-4.1910. Methods and Standards for Establishing Payment Rates–Inpatient Hospital Care: Inpatient Hospital Settlement Agreement.**

Governor's Comment:

I approve with the form and the content of this proposal. My final approval will be contingent upon a review of the public's comments.

/s/ Lawrence Douglas Wilder
Governor
Date: May 14, 1992

* * * * * * * *

Title of Regulation: **VR 460-02-4.1910. Methods and Standards for Establishing Payment Rates–Inpatient Hospital Care: Inpatient Outlier Adjustments.**

Governor's Comment:

I approve of the form and the content of this proposal. My final approval will be contingent upon a review of the public's comments.

/s/ Lawrence Douglas Wilder
Governor
Date: May 14, 1992

* * * * * * * *

Title of Regulation: **State Plan for Medical Assistance Relating to Community Mental Health/Mental Retardation Services.**
VR 460-03-3.1100. Amount, Duration and Scope of Services.
VR 460-03-3.1102. Case Management Services.
VR 460-02-3.1300. Standards Established and Methods Used to Assure High Quality Care.
VR 460-02-4.1920. Methods and Standards for Establishing Payment Rares–Other Types of Care.
VR 460-04-8.1500. Community Mental Health and Mental Retardation Services: Amount, Duration and Scope of Services.

Governor's Comment:

I approve of the form and the content of this proposal. My final comment will be contingent upon a review of the public's comments.

/s/ Lawrence Douglas Wilder
Governor
Date: May 14, 1992

* * * * * * * *

Title of Regulation: **State Plan for Medical Assistance Relating to Provider Disputes and Date of Acquisition.**
VR 460-03-4.1912. Dispute Resolution for State-Operated Providers.
VR 460-02-4.1920. Methods and Standards for Establishing Payment Rates–Other Types of Care.
VR 460-03-4.1940:1. Nursing Home Payment System (PIRS).

Governor's Comment:

I concur with the form and the content of this proposal. My final approval will be contingent upon a review of the public's comments.

/s/ Lawrence Douglas Wilder
Governor
Date: May 14, 1992

* * * * * * * *

Title of Regulation: **VR 460-03-4.1940:1. Nursing Home Payment Systems (PIRS).**

Governor's Comment:

I have no objections to these amendments.

/s/ Lawrence Douglas Wilder
Governor
Date: May 14, 1992

BOARD OF YOUTH AND FAMILY SERVICES

Title of Regulation: **VR 690-10-001. Regulations Governing the Certification Process.**

Governor's Comment:

Promulgation of these regulations would provide guidance to localities in the certification process for the operation of facilities and programs. Approval is recommended.

/s/ Lawrence Douglas Wilder
Governor
Date: May 12, 1992

Symbol Key †
† Indicates entries since last publication of the Virginia Register

GENERAL NOTICES

NOTICE

Notices of Intended Regulatory Action are published as a separate section at the beginning of each issue of the Virginia Register.

ALCOHOLIC BEVERAGE CONTROL BOARD

† Notice to the Public

A. Pursuant to the Virginia Alcoholic Beverage Control Board's "Public Participation Guidelines for Adoption or Amendment of Regulations" (VR 125-01-1, § 5.1 of the Regulations of the Virginia Alcoholic Beverage Control Board), the board will conduct a public hearing on October 28, 1992 at 10 a.m. in its hearing room, first floor, A.B.C. Board, Main Offices, 2901 Hermitage Road, City of Richmond, Virginia, to receive comments and suggestions concerning the adoption, amendment or repeal of board regulations. Any group or individual may file with the board a written petition for the adoption, amendment or repeal of any regulation. Any such petition shall contain the following information, if available.

1. Name of petitioner.

2. Petitioner's mailing address and telephone number.

3. General description of proposal, with recommendations for adoption, amendment or repeal of specific regulation(s).

4. Why is change needed? What problem is it meant to address?

5. What is the anticipated effect of not making the change?

6. Estimated costs or savings to regulated entities, the public, or others incurred by this change as compared to current regulations.

7. Who is affected by recommended change? How affected?

8. Draft language; and

9. Supporting documents.

The board may also consider any other request for regulatory change at its discretion. All petitions or requests for regulatory change should be submitted to the board no later than June 29, 1992.

B. Petitions for regulatory change should be sent to Robert N. Swinson, Secretary to the Board, P.O. Box 27491, Richmond, Virginia 23261 or may be faxed (804) 367-1802 if the original paperwork is also mailed.

C. Applicable laws or regulations (authority to adopt regulations): Sections 4-7(1), 4-11, 4-36, 4-69, 4-69.2, 4-72.1, 4-98.14, 4-103(b) and 9-6.14:1 et seq., Virginia Code; VR 125-01-1, § 5.1, Board Regulations.

D. Entities affected: (1) all licensees (manufacturers, wholesalers, importers, retailers) and (2) the general public.

E. For further information contact the undersigned at the above address or by phone at (804) 367-0626.

/s/ Robert N. Swinson
Secretary
Virginia Alcoholic Beverage Control Board

DEPARTMENT OF GENERAL SERVICES

Division of Forensic Science

† Public Notice

NOTICE: The following list of approved field tests for detection of drugs was published in 8:15 VA.R. 2494-2496 April 20, 1992, and in 8:16 VA.R. 2674-2676 May 4, 1992. The list is being reprinted to include information that was inadvertently omitted in the previous publications.

Title of Regulation: **VR 330-05-01. Regulations for the Approval of Field Tests for Detection of Drugs.**

Statutory Authority: §§ 2.1-424 and 19.2-188.1 of the Code of Virginia.

In accordance with § 2 of the Regulations for the Approval of Field Tests for Detection of Drugs and under the authority of § 19.2-188.1 of the Code of Virginia, the following Field Tests for Detection of Drugs are Approved Field Tests:

Becton Dickinson Public Safety
147 Clinton Road
West Caldwell, N. J. 07006

Drug or Drug Type	Manufacturer's Field Test
Marijuana	Test E (Duquenois-Levine Test)
Hashish	Test E (Duquenois-Levine Test)
Hashish Oil	Test E (Duquenois-Levine Test)
Cocaine Hydrochloride	Test G (Modified Scott Reagent)
Cocaine Base	Test G (Modified Scott Reagent)
Heroin	Test K (Opiates Reagent)
Codeine	Test K (Opiates Reagent)
Morphine	Test K (Opiates Reagent)
Heroin	Test L (Brown Heroin Reagent)
Barbiturates	Test C (Dille-Koppanyi, Modified)
Amphetamine	Test A (Marquis Reagent)
Methamphetamine	Test A (Marquis Reagent)
Lysergic Acid Diethylamide	Test D (LSD Reagent System)

O D V Incorporated (NarcoPouch)
Post Office Box 305
South Paris, Maine 04281

Drug or Drug Type	Manufacturer's Field Test
Narcotic Alkaloids	901 - Mayer's Reagent
Heroin	901 - Mayer's Reagent
Morphine	901 - Mayer's Reagent
Cocaine Hydrochloride	901 - Mayer's Reagent
Opiates	902 - Marquis Reagent
Heroin	902 - Marquis Reagent
Morphine	902 - Marquis Reagent
Methamphetamine	902 - Marquis Reagent
Amphetamine	902 - Marquis Reagent
Heroin	903 - Nitric Acid
Morphine	903 - Nitric Acid
Cocaine Hydrochloride	904 - Scott (Modified) Reagent
Cocaine Base	904 - Scott (Modified) Reagent
Barbiturates	905 - Dille-Koppanyi Reagent
Amphetamine	906 - Mandelin Reagent
Methamphetamine	906 - Mandelin Reagent
Methadone	906 - Mandelin Reagent
Lysergic Acid Diethylamide (LSD)	907 - Ehrlich's (Modified) Reagent
Marijuana	908 - Duquenois-Levine Reagent
Hashish	908 - Duquenois-Levine Reagent
Hashish Oil	908 - Duquenois-Levine Reagent
Tetrahydrocannabinol (THC)	908 - Duquenois-Levine Reagent
Marijuana	909 - K N Reagent
Hashish	909 - K N Reagent
Hashish Oil	909 - K N Reagent
Tetrahydrocannabinol (THC)	909 - K N Reagent
Phencyclidine (PCP)	914 - PCP Methaqualone Reagent
Methaqualone	914 - PCP Methaqualone Reagent

O D V Incorporated (NarcoPouch) continued

Drug or Drug Type	Manufacturer's Field Test
Heroin	924 - Mecke's Modified
Diazepam	925 - Valium/Diazepam Reagent
Pentazocine	926 - Talwin/Pentazocine Reagent
Ephedrine	927 - Ephedrine Reagent

O D V Incorporated (Narcotest)
Post Office Box 305
South Paris, Maine 04281

Drug or Drug Type	Manufacturer's Field Test
Narcotic Alkaloids	7601 - Mayer's Reagent
Heroin	7601 - Mayer's Reagent
Morphine	7601 - Mayer's Reagent
Cocaine Hydrochloride	7601 - Mayer's Reagent
Opiates	7602 - Marquis Reagent
Heroin	7602 - Marquis Reagent
Morphine	7602 - Marquis Reagent
Methamphetamine	7602 - Marquis Reagent
Heroin	7603 - Nitric Acid
Morphine	7603 - Nitric Acid
Cocaine Hydrochloride	7604 - Cobalt Thiocyanate Reagent
Dibucaine	7604 - Cobalt Thiocyanate Reagent
Tetracaine	7604 - Cobalt Thiocyanate Reagent
Procaine	7604 - Cobalt Thiocyanate Reagent
Barbiturates	7605 - Dille-Koppanyi Reagent
Amphetamine	7606 - Mandelin Reagent
Methadone	7606 - Mandelin Reagent
Lysergic Acid Diethylamide (LSD)	7607 - Modified Ehrlich's Reagent
Marijuana	7608 - Duquenois Reagent
Hashish Oil	7608 - Duquenois Reagent
Hashish	7608 - Duquenois Reagent
Tetrahydrocannabinol (THC)	7608 - Duquenois Reagent
Marijuana	7609 - K N Reagent
Hashish	7609 - K N Reagent
Hashish Oil	7609 - K N Reagent
Tetrahydrocannabinol (THC)	7609 - K N Reagent
Cocaine Base	7613 - Test #13 (Cocaine Free-Base Reagent)
Phencyclidine (PCP)	7614 - Test #14 (Methaqualone Reagent)
Methaqualone	7614 - Test #14 (Methaqualone Reagent)
Diazepam	7625 - Test #25 (Diazepam Reagent)
Pentazocine	7626 - Test #26 (Talwin Reagent)
Ephedrine	7627 - Test #27 (Ephedrine Reagent)

Sirchie Fingerprint Laboratories
5825 Triangle Drive
Umstead Industrial Park
Post Office Box 30576
Raleigh, N. C. 27622-0576

Drug or Drug Type	Manufacturer's Field Test
Narcotic Alkaloids	#1 - Mayers Reagent
Heroin	#1 - Mayers Reagent
Morphine	#1 - Mayers Reagent
Cocaine Hydrochloride	#1 - Mayers Reagent
Morphine	#1 - Mayers Reagent
Amphetamine	#1 - Mayers Reagent
Opium Alkaloids	#2 - Marquis Reagent
Heroin	#2 - Marquis Reagent
Amphetamine	#2 - Marquis Reagent
Meperidine (Demerol) (Pethidine)	#2 - Marquis Reagent
Heroin	#3 - Nitric Acid Reagent
Morphine	#3 - Nitric Acid Reagent
Cocaine Hydrochloride	#4 - Cobalt Thiocyanate Reagent
Procaine	#4 - Cobalt Thiocyanate Reagent
Tetracaine	#4 - Cobalt Thiocyanate Reagent
Methadone	#4 - Cobalt Thiocyanate Reagent
Barbiturates	#5 - Dille-Koppanyi Reagent
Amphetamine	#6 - Mandelin Reagent
Lysergic Acid Diethylamide (LSD)	#7 - Ehrlich's Reagent
Marijuana	#8 - Duquenois Reagent
Hashish	#8 - Duquenois Reagent
Tetrahydrocannabinol (THC)	#8 - Duquenois Reagent
Marijuana	#9 - NDB (Fast Blue B Salt) Reagent
Hashish	#9 - NDB (Fast Blue B Salt) Reagent
Tetrahydrocannabinol (THC)	#9 - NDB (Fast Blue B Salt) Reagent
Cocaine Base (Crack)	#13 - Cobalt Thiocyanate/Crack Test
Methamphetamine	#1 - Mayers Reagent
Methamphetamine	#1 - Marquis Reagent
Hashish Oil	#8 - Duquenois Reagent
Hashish Oil	#9 - NDB (Fast Blue B Salt) Reagent

DEPARTMENT OF HEALTH

Notice

Maternal and Child Health Services Block Grant Application Fiscal Year 1993

The Virginia Department of Health will transmit to the federal Secretary of Health and Human Services by July 15, 1992, the Maternal and Child Health Services Block Grant Application for the period October 1, 1992 through September 30, 1993, in order to be entitled to received payments for the purpose of providing Maternal and Child Health services on a statewide basis. These service include:

- preventive and primary care services for pregnant women, mothers, and infants up to age 1
- preventive and primary care services for children and adolescents
- family-centered, community-based, coordinated care and the development of community-based systems of services for children with special health care needs

The Maternal and Child Health Services Block Grant Application makes assurance to the Secretary of Health and Human Services that the Virginia Department of Health will adhere to all the requirements of Section 505, Title V-Maternal and Child Health Services Block Grant of the Social Security Act, as amended. To facilitate public comment, this notice is to announce a period from June 1 through June 15, 1992 for review and public comment on the Block Grant Application. Copies of the document will be available as of June 1, 1992, in the office of the Director of each county and city health department. Individual copies of the document may be obtained by contacting Ms. Rosanne Kolesar at the following address; written comments must be addressed to Ms. Kolesar and received by June 15, 1992 at the following address: Virginia Department of Health, Health Care Services, 1500 East Main Street, Room 104B, Richmond, Virginia 23219-2448, (804) 786-5214.

MARINES RESOURCES COMMISSION

† Notice of Public Hearing

The Marine Resources Commission invites public comment on proposed regulations on grey sea trout (weakfish) and speckled sea trout. The following specific proposals have been developed by commission staff after consultation with advisory committees and other representatives of the fishing industry. The commission will use considerable latitude in their final decisions regarding these regulatory proposals; the outcome of the commission's deliberations could range from closure of the trout fisheries to no additional regulations. Accordingly, the commission will consider variations to the proposals listed below, including alternate bag limits, size limits (including the use of slot limits), fishing seasons, time limits, gear restrictions, as well as the potential imposition of area restrictions, and quotas.

Grey Trout Proposal.

The overall objective of the proposed regulations for grey trout is a 25% reduction in exploitation from a base period of 1989-1990 to maintain compliance with recommendations of the Atlantic States Marine Fisheries Commission Fishery Management Plan which are designed to correct overfishing problems associated with the grey trout fisheries along the East Coast.

Pound Net Fishery: Impose minimum size limit of 10" with a 10% tolerance for undersize grey trout by weight of all grey trout in possession. Require one lift day (funnel or net tied up) per week from March 1 through November 30. A single day from each week will be specified as a lift day.

Gill Net Fishery: Impose a 12" minimum size limit of no tolerance for undersize fish. Require one lift day (gill nets removed from water) from January 1 to July 31 and from November 1 to December 31, and two lift days per week from August 1 to October 31.

Haul Seine Fishery: Impose a 10" minimum size limit with a 10% tolerance for undersize fish. Require two lift days per week from January 1 to April 30 and from June 1 to December 31, and one lift day per week from May 1 to May 31.

Trawl Fishery: Prohibit landing of grey trout in Virginia from any trawler possessing a trawl net with a cod-end mesh of less than 3".

Recreational Fishery: Two alternate bag and size limits are proposed, (1) a 12" minimum size limit with a 5 fish per day bag limit, and (2) a 13" minimum size limit with a 10 fish per day bag limit.

Other: The Commission would also like to evaluate the imposition of a moratorium on the licensing of addition pound net sites above those nets active in 1992, a restriction of 8400 feet of gill net per vessel, a requirement that all gill nets be attended while fishing from May 15 to October 15, and alternate bag and size limits for charter and head boat fisheries. For the latter, a 10" minimum size limit and 15 fish per day bag limit has been suggested.

Speckled Trout Proposal.

The commission will consider an increase in the minimum size limit for speckled trout to 13" for both recreational and commercial fisheries. In addition, a 15 fish per day bag limit is proposed for hook and line fishing. The commission will consider variations to this specific

proposal; alternatives are outlined in the first paragraph of this notice.

Public hearings on these proposals will be held on Monday, May 18, 1992 at 7 p.m. at the Eastern Shore Community College, Melfa, Virginia and at the Rappahannock Community College, Warsaw, VA; on Tuesday, May 19, 1992 at 7 p.m. at the Rappahannock Community College, Glenns, VA; on Wednesday, May 20, 1992 at 7 p.m. at the Lake Wright Quality Inn, Norfolk, VA; and after Noon on Tuesday, May 26, 1992 at the Marine Resources Commission, 2600 Washington Avenue, 4th Floor, Newport News, VA. Any interested party may submit testimony. For further information or to submit written comments, please contact the VMRC Fisheries Management Division, P.O. Box 756, Newport News, Virginia 23607.

VMRC does not discriminate against individuals with disabilities, therefore, if you are in need of reasonable accommodations due to a disability, please advise Deborah R. Cawthon (804) 247-2248 no less than 72 hours prior to the meeting time and identify your need.

† Notice of Public Hearing

The Marine Resources Commission invites public comment on proposed regulations concerning clamming in condemned areas. The Commission will consider the permanent adoption of the provisions of an emergency regulation made effective May 1, 1992 that prohibits clammers who are issued special permits for relay clams, to harvest clean clams without first turning in their permit to the VMRC Operations Office, 30 Jefferson Avenue, Newport News, VA. The permit would be held at Operations until the clammer reclaimed possession of it to harvest relay clams again.

The commission will also consider a proposed regulation prohibiting the taking and keeping of chowder clams larger than a 2-7/8" diameter ring from any relay areas, with a 10% tolerance for oversized clams by number. The proposed penalty for violation is to require the clammer to return all chowders to the clam grounds.

A public hearing on these proposals will be held on Tuesday, May 26, 1992 at noon, at the Marine Resources Commission, 2600 Washington Avenue, Newport News, VA 23607. For further information or to present written testimony, please contact the Fisheries Management Division at the above address.

VMRC does not discriminate against individuals with disabilities, therefore, if you are in need of reasonable accommodations due to a disability, please advise Joey Thompson (804) 247-2238 no less than 72 hours prior to the meeting time and identify your need.

SECRETARY OF THE COMMONWEALTH

Notice to Counties, Cities, Towns, Authorities, Commissions, Districts and Political Subdivisions of the Commonwealth

Notice is hereby given that pursuant to § 2.1-71 of the Code of Virginia, each county, city and town and each authority, commission, district or other political subdivision of the Commonwealth to which any money is appropriated by the Commonwealth or any of the above which levies any taxes or collects any fees or charges for the performance of public services or issues bonds, notes or other obligations, shall annually file with the Secretary of the Commonwealth a list of all bond obligations, the date and amount of the obligation and the outstanding balance therein, on or before June 30 of each year.

A copy of the form which may be photocopied for use herein described follows.

Statutory Authority: Section 2.1-71 of the Code of Virginia.

Contact: Sheila A. Evans, Conflict of Interest and Appointments Specialist, Post Office Box 1-D, Richmond, Virginia 23201, Old Finance Building, Capitol Square, Richmond, Virginia 23219, (804) 786-2441.

VIRGINIA CODE COMMISSION

NOTICE TO STATE AGENCIES

Change of Address: Our new mailing address is: Virginia Code Commission, 910 Capitol Street, General Assembly Building, 2nd Floor, Richmond, VA 23219. You may FAX in your notice; however, we ask that you do not follow-up with a mailed copy. Our FAX number is: 371-0169.

FORMS FOR FILING MATERIAL ON DATES FOR PUBLICATION IN THE VIRGINIA REGISTER OF REGULATIONS

All agencies are required to use the appropriate forms when furnishing material and dates for publication in the Virginia Register of Regulations. The forms are supplied by the office of the Registrar of Regulations. If you do not have any forms or you need additional forms, please contact: Virginia Code Commission, 910 Capitol Street, General Assembly Building, 2nd Floor, Richmond, VA 23219, telephone (804) 786-3591.

FORMS:

NOTICE of INTENDED REGULATORY ACTION - RR01
NOTICE of COMMENT PERIOD - RR02
PROPOSED (Transmittal Sheet) - RR03
FINAL (Transmittal Sheet) - RR04
EMERGENCY (Transmittal Sheet) - RR05
NOTICE of MEETING - RR06
AGENCY RESPONSE TO LEGISLATIVE

OR GUBERNATORIAL OBJECTIONS - RR08
DEPARTMENT of PLANNING AND BUDGET (Transmittal Sheet) - DPBRR09

Copies of the Virginia Register Form, Style and Procedure Manual may also be obtained at the above address.

ERRATA

DEPARTMENT OF WASTE MANAGEMENT

Title of Regulation: **VR 672-01-1. Public Participation Procedures for Formation and Promulgation of Regulations.**

Publication: 8:15 VA.R. 2388-2389 April 20, 1992.

Correction to Notice of Intended Regultory Action:

The department intends to **REPEAL** VR 672-01-1 which was published on February 4, 1985, as VR 352-01-1 by the Virginia Hazardous Waste Facility Siting Board. These public participation regulations were transferred to the Department of Waste Management effective July 1, 1986, in accordance with Chapter 492 of the 1986 Acts of Assembly. The VR number assigned to the regulation was changed at the time of publication of the NOIRA to conform to the classification system developed by the Virginia Code Commission and, specifically, to reflect the code assigned to the Department of Waste Management. Any questions regarding these regulations should be directed to Karol A. Akers, Policy and Planning Manager, Department of Waste Management, 101 N. 14th Street, 11th Floor, Monroe Building, Richmond, VA 23219, telephone (804) 225-2966.

CALENDAR OF EVENTS

Symbols Key
† Indicates entries since last publication of the Virginia Register
♿ Location accessible to handicapped
☎ Telecommunications Device for Deaf (TDD)/Voice Designation

NOTICE

Only those meetings which are filed with the Registrar of Regulations by the filing deadline noted at the beginning of this publication are listed. Since some meetings are called on short notice, please be aware that this listing of meetings may be incomplete. Also, all meetings are subject to cancellation and the Virginia Register deadline may preclude a notice of such cancellation.

For additional information on open meetings and public hearings held by the Standing Committees of the Legislature during the interim, please call Legislative Information at (804) 786-6530.

VIRGINIA CODE COMMISSION

EXECUTIVE

DEPARTMENT FOR THE AGING

Governor's Advisory Board on Aging

June 10, 1992 - 10 a.m. – Open Meeting
June 11, 1992 - 9 a.m. – Open Meeting
Richmond Airport Hilton, 5501 Eubank Road, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

Committee and business meetings.

Contact: Catherine Saunders, Special Assistant to the Commissioner, Virginia Department for the Aging, 700 E. Franklin Street, 10th Floor, Richmond, VA 23219, telephone (804) 225-2271, toll-free 1-800-552-3402 or (804) 225-2271/TDD ☎

Long-Term Care Ombudsman Advisory Council

June 30, 1992 - 9:30 a.m. – Open Meeting
Virginia Department for the Aging, 700 E. Franklin Street, Richmond, Virginia.

Business will include continued discussion of an initiative with a local citizen's advocacy support group.

Contact: Mark C. Miller, State Ombudsman, 700 E. Franklin Street, 10th Floor, Richmond, VA 23219, telephone (804) 225-3141, toll-free 1-800-552-3402 or (804) 225-2271/TDD ☎

DEPARTMENT OF AGRICULTURE AND CONSUMER SERVICES

Virginia Cattle Industry Board

July 9, 1992 - 10 a.m. – Open Meeting
Sheraton Red Lion Inn, Blacksburg, Virginia.

A meeting to review finances, hear research reports and updates on various ongoing projects. The board will entertain public comment at the conclusion of all other business for a period not to exceed 30 minutes.

Contact: Reginald B. Reynolds, Executive Director, Virginia Cattle Industry Board, P.O. Box 176, Daleville, VA 24083, telephone (703) 992-1009.

Virginia Marine Products Board

June 2, 1992 - 5:30 p.m. – Open Meeting
Nicks Steak and Spaghetti House, Route 17, Gloucester Point, Virginia. ♿

The board will meet to receive reports from the Executive Director of the Virginia Marine Products Board on: finance, marketing, past and future program planning, publicity/public relations, old/new business. At the conclusion of other business, the board will entertain public comments for a period not to exceed 30 minutes.

Contact: Shirley Estes Berg, 97 Main Street, Suite 103, Newport News, VA 23601, telephone (804) 594-7261.

Virginia Sweet Potato Board

† **June 10, 1992 - 8 a.m.** – Open Meeting
Eastern Shore Agriculture Experiment Station, Route 1, Box 133, Research Drive, Painter, Virginia. ♿

The board will meet to discuss and adopt the budget for 1992-93 and any other business which relates to the state's sweet potato industry. At the conclusion of all other business, the board will entertain public comments for a period not to exceed 30 minutes.

Contact: J. William Mapp, Program Director, Box 26, Onley, VA 23418, telephone (804) 787-5867.

Virginia Winegrowers Advisory Board

July 7, 1992 - 10 a.m. – Open Meeting
State Capitol Building, House Room 4, Richmond, Virginia.

A meeting to elect a new chairman and vice-chairman. In addition, the board will hear committee and project monitor reports.

Contact: Annette Ringwood, Secretary, Virginia Winegrowers Advisory Board, P.O. Box 1163, Richmond, VA 23209, telephone (804) 371-7685.

STATE AIR POLLUTION CONTROL BOARD

July 1, 1992 - 10 a.m. – Public Hearing
Board of Supervisors Meeting Room, 205 Academy Drive, N.W., Abingdon, Virginia.

July 1, 1992 - 10 a.m. – Public Hearing
Department of Air Pollution Control, Valley of Virginia Regional Office, Executive Office Park, Suite D, 5338 Peters Creek Road, Roanoke, Virginia.

July 1, 1992 - 10 a.m. – Public Hearing
Auditorium of the Recreation Center, 301 Grove Street, Lynchburg, Virginia.

July 1, 1992 - 10 a.m. – Public Hearing
Department of Air Pollution Control, Northeastern Virginia Regional Office, 300 Central Road, Suite B, Fredericksburg, Virginia.

July 1, 1992 - 10 a.m. – Public Hearing
Department of Air Pollution Control, State Capitol Regional Office, Arboretum Parkway, Suite 250, 9210 Arboretum Parkway, Richmond, Virginia.

July 1, 1992 - 10 a.m. – Public Hearing
Department of Air Pollution Control, Hampton Roads Regional Office, Old Greenbrier Village, Suite A, 2010 Old Greenbrier Road, Chesapeake, Virginia.

July 1, 1992 - 10 a.m. – Public Hearing
Department of Air Pollution Control, Northern Virginia Regional Office, Springfield Corporate Center, Suite 310, 6225 Brandon Avenue, Springfield, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Air Pollution Control Board intends to amend regulations entitled: **VR 120-01. Regulations for the Control an Abatement of Air Pollution - Documents Incorporated by Reference.** The proposed amendments to the regulations will provide the latest edition of referenced documents and incorporate recently promulgated federal New Source Performance Standards (NSPS) and National Emission Standards for Hazardous Air Pollutants (NESHAP), which are found in Rules 5-5 and 6-1, respectively. The proposed amendments will update as well the consolidated list of documents incorporated by reference found in Appendix M of the agency's regulations. The proposed amendments will incorporate the 1991-1992 edition of the American Conference of Governmental Industrial Hygienists' Handbook which forms the basis for the toxic pollutant rules, and three NSPS which were promulgated by EPA between July 1, 1990 and June 30, 1991.

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

Written comments may be submitted until July 17, 1992, to Director of Program Development, Department of Air Pollution Control, P.O. Box 10089, Richmond, Virginia.

Contact: Karen Sabasteanski, Policy Analyst, Department of Air Pollution Control, P.O. Box 10089, Richmond, VA 23240, telephone (804) 786-1624.

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† **July 8, 1992 - 10 a.m.** – Public Hearing
Board of Supervisors Meeting Room, 205 Academy Drive, N.W., Abingdon, Virginia.

† **July 8, 1992 - 10 a.m.** – Public Hearing
Department of Air Pollution Control, Virginia Western Community College, Whitman Auditorium, Business Science Building, 3095 Colonial Avenue, Roanoke, Virginia.

† **July 8, 1992 - 10 a.m.** – Public Hearing
Central Virginia Community College, Amherst Building Auditorium, Room 2123, 3506 Wards Road, Lynchburg, Virginia.

† **July 8, 1992 - 10 a.m.** – Public Hearing
Department of Air Pollution Control, Northeastern Virginia Regional Office, 300 Central Road, Suite B, Fredericksburg, Virginia.

† **July 8, 1992 - 10 a.m.** – Public Hearing
Virginia War Memorial Auditorium, 621 South Belvidere Street, Richmond, Virginia.

† **July 8, 1992 - 10 a.m.** – Public Hearing
Department of Air Pollution Control, Hampton Roads Regional Office, Old Greenbrier Village, Suite A, 2010 Old Greenbrier Road, Chesapeake, Virginia.

† **July 8, 1992 - 10 a.m.** – Public Hearing
Richard Byrd Library, Meeting Room, Fairfax County, 7250 Commerce Street, Springfield, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Air Pollution Control Board intends to amend regulations entitled: **VR 120-01. Regulations for the Control an Abatement**

of Air Pollution. The regulation amendments concern provisions covering new and modified stationary source permits. The proposed amendments revise the permit regulations for nonattainment areas (i) by redefining the definitions of "major stationary source," "net emissions increase," "nonattainment pollutant," and "significant"; (ii) by adding provisions concerning offsets, including the new offset ratios required; (iii) by adding provisions regarding de minimis increases and modification alternatives; and (iv) by making sources of nitrogen oxides subject to the same requirements as sources of volatile organic compounds. The proposed amendments also revise the permit regulations by expanding the opportunity for public participation for major source and major modification permit applications. Provisions have been added to the permit regulations concerning conformity with certain local ordinances, shutdown and reactivation of sources, transfer of permits, and revocation and enforcement of permits. The amendments also provide increases in some of the levels used to exempt certain sources.

STATEMENT

Purpose: This proposal amends the existing regulations governing the control and abatement of air pollution which are promulgated to establish standards for sources of air pollution to the extent necessary to attain and maintain such levels of air quality as will protect human health and welfare. The purpose of the regulation is to require the owner of the proposed new or expanded facility to provide such information as may be needed to enable the agency to conduct a preconstruction review in order to determine compliance with applicable control technology and other standards and to assess the impact of the emissions from the facility on air quality. The regulation also provides the basis for the agency's final action (approval or disapproval) on the permit depending upon the results of the preconstruction review.

Substance: Major provisions of the proposal are summarized below:

1. The 1990 Clean Air Act Amendments mandate certain changes to Virginia's nonattainment permit requirements covered in § 120-08-03. The major changes related to the requirements of the Clean Air Act appear in the definitions and in subsections F, M and N. The definitions of "major stationary source," "net emissions increase," "nonattainment pollutant" and "significant" have been amended to meet various requirements of Title I of the Clean Air Act. Subsection F, regarding standards, and subsection M, regarding offsets, have been amended to meet the requirements of sections 173 (a) and 182 of the Clean Air Act. Subsection N, regarding de minimis increases and modification alternatives, has been added to meet the requirements of section 182 (c) (6) - (8). Where appropriate, nitrogen oxides has been added to the language in this section regarding the relevant nonattainment pollutants.

2. Through these proposed amendments, the board is expanding the opportunity for public participation with regard to permitting. Current public participation requirements have been combined with new requirements in a separate public participation section in §§ 120-08-01, 120-08-02 and 120-08-03. In §§ 120-08-02 and 120-08-03, the proposal requires the applicant to provide public notice and an informational briefing in addition to the public hearing and public comment period now provided by the board. In § 120-08-01, the proposal requires the applicant to provide public notice only, in addition to the current public participation provisions.

3. The definition of "building, structure, or facility" in § 120-08-03 has been expanded to include installation. The definition of "installation" has been deleted. This change removes the dual definition from this section making the definition of "building, structure, facility or installation" identical to that in § 120-08-02.

4. The proposal amends the provision concerning who signs applications for permits in §§ 120-08-01, 120-08-02 and 120-08-03 to conform to similar provisions in the regulations of other state environmental agencies.

5. The proposal adds a provision to §§ 120-08-01, 120-08-02 and 120-08-03 concerning the statutory requirement for all applicants to provide notification from the locality that the location and operation of the facility are consistent with certain local ordinances.

6. The proposal adds subsections on reactivation and shutdown, transfer of permits, and revocation and enforcement of permits to §§ 120-08-01, 120-08-02 and 120-08-03.

7. The proposal amends Appendix R to provide an increase in some general exemption levels and in some specific exemption levels. The proposal also amends section IX, regarding exemption levels for sources emitting toxic pollutants, by allowing sources applying for modification permits to be exempt from the permit requirements on the basis of the increased emissions alone.

Issues: The National Ambient Air Quality Standard (NAAQS) for ozone is 0.12 parts per million (ppm). The 0.12 ppm standard was established by the U. S. Environmental Protection Agency (EPA) and is designed to protect the health of the general public with an adequate margin of safety. Numerous counties and cities within the Northern Virginia, Richmond, and Hampton Roads areas have been identified as ozone nonattainment areas pursuant to new provisions of the 1990 Clean Air Act; therefore, over 3.5 million Virginia citizens are being exposed to air quality that does not meet the federal health standard for ozone. Failure to develop adequate programs to meet the ozone air quality standard: (i) will result in continued violations of the standard to the

detriment of public health and welfare, (ii) may result in assumption of the program by EPA at which time the Commonwealth would lose authority over matters affecting its citizens, and (iii) may result in the implementation of sanctions by EPA, such as prohibition of new major industrial facilities and loss of federal funds for sewage treatment plant development and highway construction. Although the EPA has been reluctant to impose these sanctions in the past, the Clean Air Act now includes specific provisions requiring these sanctions to be issued by EPA if so warranted.

Of the consequences resulting from failure to develop an adequate program to control ozone concentrations in the ambient air, the most serious consequence will be the adverse impact on public health and welfare. A growing body of scientific data indicates that health and welfare effects associated with ozone are more serious than envisioned in the late 1970s. Some scientists believe that existing air quality standards may provide little or no margin of safety. Perhaps the most significant new finding is that ozone not only affects people with impaired respiratory systems, such as asthmatics, but also many people with healthy lungs, both children and adults. It can cause shortness of breath and coughing when healthy adults are exercising, and more serious effects in the young, old, and infirm. Recent EPA estimates suggest there are 20 to 30 million ozone-sensitive people in those major urban areas where levels are 25 percent (0.15 ppm) or more above the current health standard. The Northern Virginia Nonattainment Area is one of those major urban areas with ozone levels of up to 0.165 ppm. Equally high levels of ozone are often recorded in rural sectors downwind from these metropolitan areas.

Evidence from scientific studies of vegetation indicates that ozone can reduce plant yield in tomato, bean, soybean, snap bean, peanut, and corn crops. The potential agricultural losses nationwide are estimated to be two to three billion dollars per year. Ozone also has an impact on forests, causing premature leaf-drop and lower growth rates. Materials damage attributed to ozone includes cracking of rubber products, weakening of textiles, changes in dyes, and premature cracking of paint.

Volatile organic compounds (VOCs) and nitrogen oxides (NOX) in the ambient air react together in the presence of sunlight to form ozone. To reduce ozone concentrations in the ambient air, the emissions of NOX and VOCs (ozone precursors) from a variety of air pollution source types must be reduced. A key strategy for reducing air pollution is the control of emissions from existing stationary sources. Reduction of ozone precursors within nonattainment areas by employing available control technology on existing stationary sources can substantially reduce ozone concentrations, and in conjunction with reductions achieved from control measures on other source types, can reduce ozone concentrations to levels at or below the current health standard for ozone. However, once ozone concentrations are reduced to the level necessary to protect public health and welfare, additional strategies must be implemented to maintain those levels and address the increases in emissions due to the inherent growth often found in highly populated areas.

A key strategy for managing the growth of new emissions is the permit program for new and modified stationary sources. The program requires that owners obtain a permit from the agency prior to the construction of a new industrial or commercial facility or the expansion of an existing one. The program requirements differ according to the facility's potential to emit a specified amount of a specific pollutant and the air quality status of the various areas within the state where the facility is or will be located. Requirements for facilities considered to be major due to their potential to emit a specified pollutant are more stringent than for less polluting facilities. Requirements for major facilities located or locating in those areas which have ambient air quality concentrations that have not been maintained at or below the health-based standard for a pollutant (nonattainment areas) are considerably more stringent than for those areas which have concentrations maintained at or below the standard (prevention of significant deterioration (PSD) areas). Permits issued in nonattainment areas require the facility owner to apply control technology that meets the lowest achievable emission rate and to obtain emission reductions from existing sources in the area such that the reductions offset the increases from the proposed facility by a ratio greater than one for the emissions contributing to the nonattainment situation. Permits issued in PSD areas require the facility owner to employ control technology that is the best available and, in some cases, to monitor ambient air quality at the site where the facility will be located to determine ambient air background levels of the pollutants to be emitted. Through the implementation of new and modified source permit program, emission increases from new and expanding stationary sources can be managed so that affected areas can attain and maintain the air quality standards and accommodate growth.

The 1990 Amendments to the Clean Air Act represent the most comprehensive piece of clean air legislation ever enacted and for the first time delineates nonattainment areas as to the severity of the pollution problem. Nonattainment areas are now classified as marginal, moderate, serious, severe and extreme. Marginal areas are subject to the least stringent requirements and each subsequent classification is subject to successively more stringent control measures. Areas with higher classification of nonattainment must meet the requirements of all the areas in lower classifications plus the additional, more stringent requirements of their class. The classifications for Virginia's nonattainment areas are marginal for the Hampton Roads Nonattainment Area, moderate for the Richmond Nonattainment Area, and serious for the Northern Virginia Nonattainment Area.

Section 182 (a)(2)(C) of the Act sets out the general requirements for new source review programs in all nonattainment areas and mandates a new and modified

major stationary source permit program that meets the requirements of Sections 172 and 173 of the Act. Section 172 contains the basic requirement for a permit program, while section 173 contains the specifics which are summarized below.

Section 173 (a) provides that a permit may be issued if the following criteria are met:

1. Offsets have been obtained for the new or expanding sources from existing sources so that total allowable emissions (i) from existing sources in the region, (ii) from new or modified sources which are not major emitting facilities, and (iii) from the proposed new source will be sufficiently less than total emissions from existing sources prior to the application for the permit so as to represent reasonable further progress.

2. The proposed source is required to comply with the lowest achievable emission rate.

3. The owner of the proposed source has demonstrated that all major stationary sources owned or operated by the owner in the state are subject to emission limitations and are in or on a schedule for compliance with all applicable emission limitations or standards.

4. The State Implementation Plan is being adequately implemented for the nonattainment area in which the proposed source is to be located.

5. An analysis of alternative sites, sizes, production processes, and environmental control techniques for the proposed source demonstrates that benefits of the proposed source significantly outweigh the environmental and social costs imposed as a result of its location, construction, or modification.

Section 173 (b) prohibits the use of any growth allowance that is part of a SIP revision in effect prior to the adoption of the new Act for areas designated nonattainment after adoption of the new Act.

Section 173 (c) provides that the owner of the proposed new or modified source may obtain offsets only from the nonattainment area in which the proposed source is to be located. However, the permit program may provide that offsets may be obtained from other nonattainment areas whose emissions impact in the area where the proposed source is to be located, provided the other nonattainment area has an equal or higher classification and the offsets are based on actual emissions.

Section 173 (d) provides that states must promptly submit any control technology information relative to the permit program to EPA for entry into the BACT/LAER clearinghouse.

Section 173 (e) provides that the permit program must allow the use of alternative or innovative means to achieve offsets for emission increases due to rocket engine and motor firing and cleaning related to the firing.

A major stationary source is defined for general application in Section 302 of the Act as "any facility or source of air pollutants which directly emits, or has the potential to emit, one hundred tons per year or more of any air pollutant." For nonattainment areas defined as serious or worse, Section 182 (c) specifically defines a major stationary source as a facility emitting fifty tons per year or more. Section 182 (f) provides that requirements which apply to major stationary sources of VOCs under the Act shall also apply to major stationary sources of NOX.

Section 182 (a)(4) of the Act sets out the requirements for marginal areas (Hampton Roads) with respect to offset ratios, providing for a minimum ratio of total emissions reduction of VOCs to total increased emissions of VOCs of 1.1 to 1. Likewise Section 182 (b)(5) sets out the offset requirements for moderate nonattainment areas (Richmond), specifying the ratio to be at least 1.15 to 1. Finally, Section 182 (c)(10) sets out the offset requirements for serious nonattainment areas (Northern Virginia), specifying the ratio to be at least 1.2 to 1.

Sections 182 (c)(6) through (c)(8) contain some additional specifics for serious or worse nonattainment areas concerning the establishment of a de minimis level for expanding existing sources and the allowance of internal offsets as an alternative to the permit requirements. New source permit programs must include provisions to require permits for modifications of all existing sources unless the increase in net emissions from the source does not exceed 25 tons when aggregated with all other net increases in emissions from the source over any period of five consecutive calendar years, including the calendar year in which the increase occurs. The program must also include provisions concerning internal offsets as alternatives to the permit requirements. For sources emitting less than 100 tons per year and applying for a permit to expand, a permit will be required unless the owner elects to offset the increase by a greater reduction in emissions of the same pollutant from other operations, units, or activities within the source at an internal offset ratio of at least 1.3 to 1. If the owner does not choose the option of an internal offset, a permit will be required but the control technology level required will be best available control technology (BACT) instead of lowest achievable emission rate (LAER). For sources emitting 100 tons or more per year and applying for a permit to expand, control technology requirements which constitute LAER will be required unless the owner elects to offset the increase by a greater reduction in emissions of the same pollutant from other operations, units, or activities within the source at an internal offset ratio of at least 1.3 to 1.

Basis: The legal basis for the proposed regulation amendments is the Virginia Air Pollution Control Law, Title 10.1, Chapter 13 of the Code of Virginia.

Impact: Clean Air Act amendment changes. The sources affected by the source definition changes mandated by the Clean Air Act are as follows:

a. Northern Virginia nonattainment area

(i) Volatile organic compounds. Major new sources that will emit between 50 and 100 tons per year, and major sources that increase their significant emissions rate by an amount between 25 and 40 tons per year.

(ii) Nitrogen oxides. Major new sources that will emit 50 tons per year or more, and major sources that increase their significant emissions rate by 25 tons per year or more.

b. Richmond and Hampton Roads Nonattainment Areas

Major new sources that will emit 100 tons per year or more of nitrogen oxides, and major sources that increase their significant emissions rate of nitrogen oxides by 40 tons per year or more.

The specific types of sources affected by these changes can be differentiated by the pollutant emitted. The majority of sources emitting nitrogen oxides are industrial and utility boilers. The majority of sources emitting volatile organic compounds at a rate between 50 and 100 tons per year are printing facilities and some gasoline bulk terminals. Until the Department has some experience with the permit applications received under these changes, any estimation of the number of entities affected would be speculative.

The sources newly being brought into nonattainment permit review under the proposed regulation changes mandated by the Clean Air Act are affected by two kinds of costs: offsets and control technology costs. Under the pre-1990 Clean Air Act permit requirements, permit applications from these sources were reviewed for nitrogen oxides as well as volatile organic compounds at all levels of emission rates. Therefore, the initial permit application preparation should not be considered a cost increase under these proposed regulations. However these sources will now be required to obtain offsets of emissions and apply the lowest achievable emission rate control technology.

In applying the lowest achievable emission rate (LAER) control technology, the Clean Air Act stipulates by definition that the level of emissions control to be met is the most stringent emissions limitation contained in the state implementation plan for the class or category of stationary source or which is achieved in practice by that class or category of stationary source. Unlike best available control technology (BACT), the control technology level required for new and modified sources in areas that are in attainment, cost cannot be a consideration. Because the standards to meet LAER are high, the costs for this level of control technology also tend to be high. Furthermore for each type of stationary source there are a limited number of pollution control technologies available that are feasible for the source type. Therefore differing levels of control technologies may overlap; sometimes the same control technology is both LAER and BACT for a stationary source. Another factor of importance in considering the cost of control technology is that what may be considered BACT or LAER for any specific stationary source will change fairly rapidly because the state of the art of control technology changes rapidly. One way to determine the cost of any level of control technology is cost effectiveness. The cost effectiveness of a pollution control system is a simple ratio of the projected cost of the control system to the amount of emissions that would be controlled. The resulting cost effectiveness can then be compared to that of other related controls to provide a measure of how "reasonable" the system is relative to the others. Thus, the cost effectiveness value for a particular control system is usually expressed in terms of dollars per ton of pollutant removed by the control system. The cost effectiveness value is obtained by adding the capital costs for the control equipment to the operating and maintenance costs and amortizing that sum over an appropriate period of time. The result is called the annualized cost. Dividing this value by the tons of pollutant removed gives the cost effectiveness value.

Since cost effectiveness values are given for a wide range of control technology options, it would seem appropriate, when discussing the cost effectiveness values for LAER, to select those options that provide the higher end of the scale of emissions reduction for the pollutant being emitted. For volatile organic compounds, it will be assumed here that LAER provides 90 percent or greater emissions reduction. For the control of volatile organic compound emissions from selected stationary source categories, some control options that provide 90 percent or greater emissions reduction are: condenser filters with carbon for ink emissions from web offset lithography; carbon adsorption for process vent emissions from hazardous waste treatment, storage and disposal facilities; covers vented to destruction devices including incinerators and carbon absorbers for emissions from tanks, containers, and surface impoundments at hazardous waste treatment, storage and disposal facilities; incineration of emissions from ethylene oxide, phenol, terephthalic acid, or acrylonitrile manufacture; equipment and maintenance controls for fugitive emissions from petroleum refining; and incineration of emissions from paper surface or miscellaneous surface coating. The range of cost effectiveness values for these and other similar control options is $1-$5700 per ton in annualized costs for about a 15-year period, to include, for the same range, about $5-$28,500 of the total in capital costs.

The major stationary sources of nitrogen oxides are utility boilers, industrial boilers, IC engines, gas turbines, and process heaters. For the control of nitrogen oxide emissions from these sources, selective catalytic reduction (SCR) is usually considered LAER, as well as BACT. SCR

generally provides 80 percent reduction of nitrogen oxide emissions, although with the addition of water injection the percentage of emissions reduced is 94 percent. Also SCR used with process heaters provides 90 percent reduction of nitrogen oxide emissions. The cost effectiveness values for these sources of nitrogen oxides using SCR varies with the size of the units, and show a definite economy of scale. For utility boilers in the 50-60 MW size, the cost effectiveness values ange from $2800 to $5700 per ton in annualized costs for about a 15-year period, to include for the same range about $14,000-$28,500 of the total in capital costs. For utility boilers in the 940-975 MW size, the cost effectiveness values range from $2200-$4400 per ton in annualized costs for about a 15-year period, to include for the same range about $11,000-$22,000 of the total in capital costs. For industrial boilers in the 2-3 MW size, the cost effectiveness values range from $4700-$18,700 per ton in annualized costs for about a 15-year period, to include for the same range about $23,500-$93,500 of the total in capital costs. For industrial boilers in the 9.5-120 MW size, the cost effectiveness values range from $2100-$12,700 per ton; in annualized costs for about a 15-year period, to include for the same range about $10,500-$63,500 of the total in capital costs.

For internal combustion engines in the 5-263 MW size, the cost effectiveness values range from $124-$912 per ton in annualized costs for about a 15-year period, to include for the same range about $620-$4560 of the total in capital costs. For gas turbines in the 105-8295 MW size, the cost effectiveness values range from $2400-$4000 per ton in annualized costs for about a 15-year period, to include for the same range about $12,000-$20,000 of the total in capital costs. For process heaters in the 11-420 MW size, the cost effectiveness values range from $2000-$13,000 per ton in annualized costs for about a 15-year period, to include for the same range about $10,000-$65,000 of the total in capital costs.

The cost of offsets of volatile organic compounds and nitrogen oxides will be determined at any one time by the marketplace. Some offsets for these pollutants have been bought in the Commonwealth but the price paid is confidential between the buyer and seller. However it is clear that the cost of offsets is determined to some extent by the cost of the control technology required to reduce emissions since the reduction of emissions is necessary to provide the offset.

General Changes. The sources affected by the general changes to the new and modified stationary source permit regulations are each new and modified stationary source that must be reviewed under these proposed regulations. Based on recent annual statistics, the Department anticipates that approximately 350 new and modified stationary source permit applications will be submitted for review annually in the next few years.

The only new costs to affected sources are the costs associated with enhanced public participation for applicants. For major sources not covered under the prevention of significant deterioration or nonattainment rules, the proposed amendments require the applicant to place a notice in a newspaper in the affected air quality control region concerning the source's application. Based on the experience of the Department in publishing public hearing notices, the cost of printing the notice in a newspaper should be in the range of $100 to $600, which would depend on the newspaper used and the length of the notice. This does not include the cost of writing the notice and arranging for publication. For major sources covered under the prevention of significant deterioration or nonattainment rules, the proposed amendments require the applicant to place a notice in a newspaper in the affected air quality control region concerning the source's application and to hold an informational briefing for the public. The cost of holding the briefing includes the potential cost of renting a meeting room and the cost of preparing for the briefing as well as the cost of time spent giving the briefing. Although some meeting rooms can be reserved for free, this is not always the case. Based on the experience of the Department in holding public hearings, the cost of reserving a meeting room varies but probably would not exceed $125. The cost of preparing a briefing is equal to the hourly salary of the person or persons doing the preparation multiplied by the hours of preparation and meeting time. The cost may also include making slides or overheads for the presentation. This cost would vary considerably from situation to situation but a reasonable average is $2500.

Small Business Impact: The proposed amendments limit the impact on small businesses by providing an increase in the levels for exemption from the requirements for a permit under § 120-08-01:

1. From 350,000 to 1,000,000 Btu per hour for fuel burning equipment using solid fuel.

2. For new sources with uncontrolled emission rates, from 10 to 40 tons per year for emissions of nitrogen dioxide and sulfur dioxide, from 1 to 15 tons per year for emissions of particulate matter, and from 7 to 25 tons per year for emissions of volatile organic compounds.

3. For modified sources with uncontrolled emission rates, from 1 to 10 tons per year for emissions of particulate matter, and from 7 to 10 tons per year for emissions of volatile organic compounds.

The proposed amendments further limit the impact on small businesses by providing an exemption from minor source permits for any addition of, relocation of or change to a woodworking machine within a wood product manufacturing plant, and for any wood sawmill. The proposed amendments also decrease the impact of the permit requirements of § 120-08-01 on small businesses by limiting the public hearing requirements to major modifications of a certain size and public comment and public hearings to air quality issues generally.

Impact on the Department: It is not expected that the regulation amendments will result in any cost to the Department beyond that currently in the budget.

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

Written comments may be submitted until July 31, 1992, to Director of Program Development, Department of Air Pollution Control, P.O. Box 10089, Richmond, Virginia.

Contact: Nancy S. Saylor, Policy Analyst, Department of Air Pollution Control, P.O. Box 10089, Richmond, VA 23240, telephone (804) 786-1249.

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† **July 15, 1992 - 10 a.m.** – Public Hearing
Board of Supervisors Meeting Room, 205 Academy Drive, N.W., Abingdon, Virginia.

† **July 15, 1992 - 10 a.m.** – Public Hearing
Department of Air Pollution Control, Valley of Virginia Regional Office, Executive Office Park, Suite D, 5338 Peters Creek Road, Roanoke, Virginia.

† **July 15, 1992 - 10 a.m.** – Public Hearing
Department of Air Pollution Control, Central Virginia Regional Office, 7701-03 Timberlake Road, Lynchburg, Virginia.

† **July 15, 1992 - 10 a.m.** – Public Hearing
Department of Air Pollution Control, Northeastern Virginia Regional Office, 300 Central Road, Suite B, Fredericksburg, Virginia.

† **July 15, 1992 - 10 a.m.** – Public Hearing
Virginia War Memorial Auditorium, 621 South Belvidere Street, Richmond, Virginia.

† **July 15, 1992 - 10 a.m.** – Public Hearing
Department of Air Pollution Control, Hampton Roads Regional Office, Old Greenbrier Village, Suite A, 2010 Old Greenbrier Road, Chesapeake, Virginia.

† **July 15, 1992 - 10 a.m.** – Public Hearing
Richard Byrd Library, Meeting Room, Fairfax County, 7250 Commerce Street, Springfield, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Air Pollution Control Board intends to amend regulations entitled: **VR 120-01. Regulations for the Control an Abatement of Air Pollution.** The regulation amendments require owners of gasoline dispensing facilities, pumping more than 10,000 gallons per month, in certain localities in the Richmond and Northern Virginia areas to install and operate Stage II vapor recovery systems. An exemption has been allowed for facilities pumping 50,000 gallons per month or less that are owned by independent small business gasoline marketers. Stage II systems must be installed between January 1, 1993, and November 15, 1994, depending on date of facility construction and amount of gasoline pumped monthly.

STATEMENT

Purpose: The purpose of the proposed amendments is to change the board's regulations concerning emission standards for volatile organic compounds from petroleum liquid storage and transfer operations to require the owner of a gasoline dispensing facility to install and operate a vapor recovery system for the control of volatile organic compound emissions, such that resultant ozone concentrations in the ambient air may be reduced to levels which are necessary for the protection of public health and welfare.

Substance: The major provisions of the proposal are summarized below:

1. Require owners of gasoline dispensing facilities in moderate or worse nonattainment areas (Richmond and Northern Virginia Emissions Control Areas) with an average monthly throughput of more than 10,000 gallons to install and operate a control system for recovery of gasoline vapors emitted during the fueling of motor vehicles. The localities included in the Northern Virginia and Richmond Emissions Control Areas are the same as those in the Northern Virginia and Richmond Nonattainment Areas.

2. Require owners of gasoline dispensing facilities which begin actual construction on or after January 1, 1993, to install and operate vapor recovery systems upon start-up, unless proven exempt from the Stage II vapor recovery system requirements. Require owners of facilities which begin actual construction after November 15, 1990, and before January 1, 1993, to install and operate vapor recovery systems by May 15, 1993. Require owners of facilities which begin actual construction on or before November 15, 1990, and dispense an average monthly throughput of 100,000 gallons or more of gasoline to install and operate vapor recovery systems by November 15, 1993. Facilities which begin construction on or before November 15, 1990 and dispense an average monthly throughput of less than 100,000 gallons, but more than 10,000 gallons of gasoline, must install and operate vapor recovery systems by November 15, 1994.

3. Allow an exemption for gasoline dispensing facilities with an average monthly throughput of 50,000 gallons or less that are owned by an independent small business gasoline marketer.

4. Allow an exemption for gasoline dispensing devices which are used exclusively to refuel marine vehicles, aircraft, farm equipment and emergency vehicles.

5. Provide authority for requiring Stage II vapor recovery system operator training, equipment approval, testing, inspection, maintenance and all associated

recordkeeping and reporting. Detailed procedures for these requirements are in an air quality program policies and procedures document.

Issues: A variety of alternatives to the proposed regulation were considered. These included:

1. Require Stage II vapor recovery systems for affected gasoline dispensing facilities (i) only in the Richmond and Northern Virginia Ozone Emissions Control Areas, (ii) in all three ozone Emissions Control Areas, or (iii) throughout the state; or not amend the regulations.

2. Allow an exemption from Stage II vapor recovery systems (i) only for facilities with a monthly throughput of 10,000 or less gallons, (ii) for facilities owned by independent small business gasoline marketers with a monthly throughput of 50,000 gallons or less, in addition to the 10,000 gallon per month exemption, or require Stage II vapor recovery systems on all gasoline dispensing facilities regardless of monthly throughput.

3. Provide new or modified gasoline dispensing facilities an exemption from Stage II vapor recovery systems (i) only for facilities with a monthly throughput of 10,000 or less gallons, (ii) for facilities owned by independent small business gasoline marketers with a monthly throughput of 50,000 gallons or less, in addition to the 10,000 gallon per month exemption, or require Stage II vapor recovery systems on all gasoline dispensing facilities regardless of monthly throughput.

Basis: The legal basis for the proposed regulation amendments is the Virginia Air Pollution Control Law, Title 10.1, Chapter 13 of the Code of Virginia.

Impact:

1. Entities affected. The affected facilities are those private and public (retail) gasoline dispensing facilities pumping an average monthly throughput greater than 10,000 gallons, and gasoline dispensing facilities owned by independent small business gasoline marketers that pump an average monthly throughput of 50,000 gallons or more.

Approximately 350-400 retail facilities will be required to install Stage II vapor recovery systems in the Richmond Emissions Control Area, and 700-800 retail facilities will be required to install Stage II systems in the Northern Virginia Emissions Control Area. There will be a much smaller number of private gasoline facilities required to install and operate Stage II vapor controls. Private facilities include those owned by government agencies, farming operations and those companies not engaged in the sale of gasoline. EPA estimates, on a national scale, ten percent or fewer privately-owned facilities have an average monthly throughput greater than 10,000 gallons and, consequently, will not be required to install Stage II vapor controls. EPA also estimates there are slightly more private facilities nationwide than retail facilities. By applying these EPA estimates to the estimated number of regulated retail facilities, it is estimated that roughly 35-40 and 70-80 private facilities will be required to install Stage II vapor recovery systems in the Richmond and Northern Virginia Emissions Control Areas, respectively.

The regulation is designed to limit the impact on small businesses by exempting facilities pumping an average monthly throughput of 10,000 gallons or less and by exempting facilities pumping an average monthly throughput of 50,000 gallons or less which are owned by independent small business gasoline marketers.

2. Fiscal impact.

a. Costs to affected entities.

The costs of Stage II vapor recovery systems are most easily compared by looking at aboveground and underground components separately. The reason for this is that the cost of installing aboveground equipment is governed by the type of system installed, while the cost of installing underground equipment is governed by the layout of the station and whether other necessary underground work can be accomplished at the same time.

The capital cost for Stage II aboveground equipment and installation for a typical station with nine dispenser nozzles and average monthly sales of 50,000 gallons is approximately $17,000. The annual cost of Stage II equipment (primarily for the repair and replacement of hoses and nozzles) is about $3,000.

The cost of installing underground pipes is harder to estimate due to the many types of station layouts (orientation of islands and tanks). The cost of pipe installation for a nine-nozzle station with monthly sales of 50,000 gallons ranges from $7,000 to $8,000, depending on which Stage II vapor recovery system is used. Substantial savings can be realized, however, if pipes are installed when other work is being done on underground tanks, such as that needed to comply with the federal Underground Storage Tank program. EPA estimates a savings of 5% to 20% in total Stage II vapor recovery system costs if piping is installed concurrently with other underground work.

The cost of Stage II equipment and installation is offset slightly by the capture and recirculation into the underground storage tank of gasoline vapors that normally escape to the atmosphere during vehicle refueling. EPA estimates this conservation effect at

roughly 2/10 of one percent of the gasoline that is dispensed, or about two gallons out of every thousand pumped. The gasoline savings that would result from the implementation of a Stage II vapor recovery program, with a 10,000 gallon per month exemption for non-independent small business marketers of gasoline and a 50,000 gallon per month exemption for independent small business marketers, in the Northern Virginia and Richmond Emissions Control Areas is approximately 986,000 gallons per year and 501,600 gallons per year, respectively.

b. Costs to agency.

The Department of Air Pollution Control and the Department of Agriculture and Consumer Services (DACS) are working together to determine which agency can most effectively and efficiently enforce the Stage II regulation. The Weights and Measures Office of the DACS has traditionally regulated any piece of equipment that is involved with the metering and sale of gasoline, and this office currently inspects gasoline facilities for compliance with these regulations. Once it is determined which agency will assume enforcement responsibility for the Stage II regulation, requests will be made for adjustments to that agency's budget as appropriate.

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

Written comments may be submitted until July 31, 1992, to Director of Program Development, Department of Air Pollution Control, P.O. Box 10089, Richmond, Virginia.

Contact: Ellen Snyder, Policy Analyst, Department of Air Pollution Control, P.O. Box 10089, Richmond, VA 23240, telephone (804) 786-0177.

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† **July 22, 1992 - 10 a.m.** – Public Hearing
Board of Supervisors Meeting Room, 205 Academy Drive, N.W., Abingdon, Virginia.

† **July 22, 1992 - 10 a.m.** – Public Hearing
Department of Air Pollution Control, Valley of Virginia Regional Office, Executive Office Park, Suite D, 5338 Peters Creek Road, Roanoke, Virginia.

† **July 22, 1992 - 10 a.m.** – Public Hearing
Department of Air Pollution Control, Central Virginia Regional Office, 7701-03 Timberlake Road, Lynchburg, Virginia.

† **July 22, 1992 - 10 a.m.** – Public Hearing
Department of Air Pollution Control, Northeastern Virginia Regional Office, 300 Central Road, Suite B, Fredericksburg, Virginia.

† **July 22, 1992 - 10 a.m.** – Public Hearing
Virginia War Memorial Auditorium, 621 South Belvidere Street, Richmond, Virginia.

† **July 22, 1992 - 10 a.m.** – Public Hearing
Department of Air Pollution Control, Hampton Roads Regional Office, Old Greenbrier Village, Suite A, 2010 Old Greenbrier Road, Chesapeake, Virginia.

† **July 22, 1992 - 10 a.m.** – Public Hearing
Richard Byrd Library, Meeting Room, Fairfax County, 7250 Commerce Street, Springfield, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Air Pollution Control Board intends to amend regulations entitled: **VR 120-01. Regulations for the Control an Abatement of Air Pollution.** The regulation amendments concern provisions covering emission standards for volatile organic compounds (VOC) and nitrogen oxides (NOX) from stationary sources located in certain localities in the Northern Virginia, Richmond and Hampton Roads areas. The proposal (i) will require owners of stationary sources to report the levels of emissions from the sources in order to assess compliance with emission and air quality standards and (ii) will require owners of specified major stationary sources to limit VOC and NOX emissions to a level resultant from the use of reasonably available control technology (RACT) and necessary for the protection of public health and welfare.

STATEMENT

Purpose:

A. The purpose of the reporting regulation is to require the owner to report the levels of emissions from the source in order to assess compliance with emission and air quality standards.

B. The purpose of the standards is to require the owner of a specified source to limit volatile organic compound (VOC) and nitrogen oxides (NOX) emissions to a level resultant from the use of reasonably available control technology (RACT) and necessary for protection of public health and welfare.

Substance: Major provisions of the proposal are summarized below.

A. Reporting requirements for emissions from stationary sources of VOC and NOX.

Revise the provisions covering the submittal of registration information (§ 120-02-31) to require emission statements for stationary sources emitting 25 tons per year or more of VOC and NOX in any of the emissions control areas.

B. Emission standards for stationary sources of VOC and NOX.

1. Expand the VOC Emissions Control Areas (Appendix P) to include all of the new nonattainment localities in the Northern Virginia and Richmond Nonattainment Areas and establish new NOX Emissions Control Areas (Appendix P) to include all of the same localities as in the expanded VOC Emissions Control Areas.

2. Revise the existing VOC emission standard (§ 120-04-0407) for non-CTG sources to require reasonably available control technology (RACT) for all sources emitting 50 tons per year or greater of VOC in the Northern Virginia emissions control area.

3. Establish a NOX emission standard (§ 120-04-0408) for non-CTG sources to require RACT for:

A. All sources emitting 50 tons per year or greater of NOX in the Northern Virginia emissions control area; and

B. All sources emitting 100 tons per year or greater of NOX in the Richmond emissions control area.

Issues: A variety of alternatives were considered in developing the proposed regulation. These included:

A. Reporting requirements for emissions from stationary sources of VOC and NOX: (i) require emissions statements in the Northern Virginia, Richmond, and Hampton Roads Emissions Control Areas for just VOC and NOX; (ii) require emissions statements only in Emissions Control Areas for all pollutants, (iii) require emission statements on a statewide basis for all pollutants, or (iv) not amend the regulations, which currently do not require emissions statements.

B. Emission standards for stationary sources of VOC and NOX.

1. (a) Expand the list of VOC Emissions Control Areas in Appendix P, thus requiring sources in all nonattainment localities in the Northern Virginia and Richmond VOC Emissions Control Areas to comply with the existing source VOC emission standards, (b) require sources in the Northern Virginia, Richmond, and Hampton Roads VOC Emissions Control Areas to comply with existing source VOC emission standards, (c) require sources to comply with existing source VOC emission standards on a statewide basis, or (d) not change the applicability of the existing source VOC emission standards.

2. (a) Require RACT on non-CTG sources emitting 50 tpy or greater of VOC or NOX in the Northern Virginia Emissions Control Area and on non-CTG sources emitting 100 tpy or greater of VOC or NOX in the Richmond Emissions Control Area; (b) require RACT on non-CTG sources emitting 50 tpy or greater VOC or NOX in the Northern Virginia, Richmond, and Hampton Roads Emissions Control Areas, (c) require statewide RACT on non-CTG sources emitting 50 tpy or greater of NOX or VOC, or (d) not change the current standards which require RACT on non-CTG sources emitting 100 tpy or greater VOC in Richmond and Northern Virginia Nonattainment Areas.

Basis: The legal basis for the proposed regulation amendments is the Virginia Air Pollution Control Law (Title 10.1, Chapter 13 of the Code of Virginia).

Impact:

A. Reporting requirements for emissions from stationary sources of VOC and NOX.

1. Entities affected.

The proposed reporting regulation will affect owners of stationary sources emitting 25 tons per year or more of VOC or NOX and located in any of the current or new localities in the VOC or NOX Emissions Control Areas. This includes approximately 160 facilities in the affected localities which encompass the entire range of source sizes and types, from small printing facilities to large chemical plants and power plants.

2. Fiscal impact.

a. Costs to affected entities. The costs of this regulation for affected entities will depend entirely on the specific situation for each source. Costs will vary from source to source due to the size and complexity of each source. The highest costs incurred will be the costs to provide the initial data. When the data is updated the costs will be considerably lower.

Due to the variability among the entities affected by this proposed regulation, an estimation of costs is given by a range from small to large or more complex sources or facilities. The primary cost will that of collecting and providing data to the department. Filling out the forms initially will take considerable time for those sources not included in the current data base. However, most sources now report emissions and operational data to the department at specific intervals depending on the size of the source. This data is required to maintain the state's emissions inventory and to verify compliance with the regulations. For sources already in the data base, the new system will require verifying or updating information already provided to the department. While this effort may be time consuming it probably will not take as much effort as initially developing the data.

The cost to prepare the initial statement will range from $100 for a small source to $10,000 for a large source. The cost for an update will range from $80 for a small source to $2,200 for a large source. A small source is assumed here to mean one 2ite where one stack from a simple process emits either

one or a few pollutants. A large source is assumed here to mean one site where hundreds of stacks emit a multiplicity of pollutants and where the processes creating these emissions are complex.

b. Costs to agency.

It is not expected that the regulation amendments will result in any cost to the department beyond that currently in the budget.

B. Emission Standards for stationary sources of VOC and NOX.

1. Entities affected.

The changes to the geographic applicability of the current standards for CTG sources will affect owners of a variety of sources located in the new localities in the Richmond VOC Emissions Control Area. This includes over 100 facilities in the affected localities which encompass the entire range of source sizes and types, from small degreasing operations to larger printing facilities.

Specifically this includes two printing facilities, about ten gasoline bulk plants, about 60 gasoline dispensing facilities and about 10n dry cleaning plants. It also includes several solvent degreasing operations; however, the number of these facilities is unknown because they are not in the department's data base.

The changes to the geographic applicability of the current standards and the establishment of new standards for non-CTG sources will affect owners of specified sources of VOC and NOX emitting (i) 50 tons per year or greater of either pollutant in the Northern Virginia emissions control area, (ii) 100 tons per year or greater of VOC in the new localities of the Richmond emissions control area, and (ii) 100 tons per year or greater of NOX in the current and new localities of the Richmond emissions control area.

Specifically for sources of VOC in the Richmond area, this includes two large chemical plants and three large paper processing plants. For sources of VOC in the Northern Virginia area, this includes one power plant, aircraft deicing operations at two aviation service facilities, one polystyrene processing facility, three lithographic printing facilities, one dry cleaner, and metal and wood furniture coating operations at a correctional facility.

Specifically for sources of NOX in the Richmond area, this includes 17 fuel burning equipment units at four utility plants, 95 fuel burning equipment units at nine industrial plants, several process combustion units, and one adipic acid plant. For sources of NOX in the Northern Virginia area, this includes 15 fuel burning equipment units at three utility plants, 173 fuel burning equipment units at eight industrial plants and government facilities.

2. Fiscal impact.

a. Costs to affected entities.

In defining levels of control, pollution cannot totally be eliminated in most situations. Therefore, the issue becomes defining the appropriate level of control. With this in mind, a two tier approach for defining the appropriate level of control has been developed. For new facilities, the emissions must be controlled using best available control technology (BACT). For existing facilities, where retrofit is a problem, only reasonably available control technology (RACT) is required to be used, usually less restrictive than BACT. To select RACT, cost effectiveness is used as one tool. It is useful for comparing various control systems among themselves. The cost effectiveness of a pollution control system is a simple ratio of the projected cost of the control system to the amount of emissions that would be controlled. The resulting cost effectiveness can then be compared to that of other related controls to provide a measure of how "reasonable" the system is relative to the others. Thus, the cost effectiveness value for a particular control system is usually expressed in terms of dollars per ton of pollutant removed by the control system. The cost effectiveness value is obtained by adding the capital costs for the control equipment to the operating and maintenance costs and amortizing that sum over an appropriate period of time. The result is called the annualized cost. Dividing this value by the tons of pollutant removed gives the cost effectiveness value. In the absence of more definitive information, this approach was used to develop the cost impact data provided below.

The emission standards for CTG sources contain specific emission limits and other requirements relating to compliance, testing, monitoring, recordkeeping and reporting. For this reason, the available cost impact data is more definitive. The initial analysis and impact assessment by the Department indicates the following impact upon the various facility types affected. The impact upon the two printing facilities is expected to be minimal because the two facilities are currently able to meet the standard with existing control equipment. The cost to meet the standard for a typical gasoline bulk plant will be about $5,000 in annualized costs for about a 15-year period, to include about $34,000 in capital costs. The cost to meet the standard for a typical gasoline dispensing facility will be about $500 to $2,000 in capital costs depending on the situation and degree of retrofit. The cost to meet the standard for a typical dry cleaning operation will be about $750 in annualized costs for about a 15 year period, to include about $3,750 in capital costs for small operations and a cost savings for the medium and larger units. The cost to meet the standard for

a typical solvent degreasing operation will be a cost savings.

On the other hand, the emission standards for non-CTG sources of VOC do not contain specific emission limits and other requirements. For this reason, the available cost impact data is much less definitive. The standards are structured to provide for the establishment of the specific emission limits, achievable by the use of reasonably available control technology (RACT), and other necessary requirements on a case-by-case basis. This approach is taken because most of the non-CTG sources are unique as to source type and size. These specific requirements, once determined, would be enforced through an operating permit issued by the board. The initial analysis and impact assessment by the department indicates the following impact upon the various facility types affected.

For sources of VOC in the Richmond area, the impact upon the two large chemical plants is expected to be minimal because the facilities are currently able to meet expected RACT limits with existing control equipment. The total cost to meet expected RACT limits for the three large paper processing plants is estimated to be about $2.24 million in annualized costs for about a 15-year period, to include about $11.2 million in capital costs. For sources of VOC in the Northern Virginia area, the impact upon the power plant and two aviation service facilities is expected to be minimal because the facilities are currently able to meet expected RACT limits with existing control equipment. The cost to meet expected RACT limits for the polystyrene processing facility is estimated to be about $100,000 in annualized costs for about a 15-year period, to include about $500,000 in capital costs. The impact upon the three lithographic printing facilities is unknown but will not be immediate; EPA is in process of developing a CTG to define the RACT limits for this source type and implementation of the regulation will be delayed until the EPA promulgation. The cost to meet the RACT limits for a typical dry cleaning plant will be a cost savings since it only impacts medium and larger units. The cost to meet the RACT limits for a typical wood furniture coating operation will be about $17,500 in annualized costs for about a 15 year period, to include about $87,500 in capital costs.

The emission standards for non-CTG sources NOX also do not generally contain specific emission limits and other requirements. For this reason, the available cost impact data is much less definitive. The standards are structured to provide for the establishment of the specific emission limits, achievable by the use of reasonably available control technology (RACT), and other necessary requirements on a case-by-case basis. This approach is taken because most of the non-CTG sources are unique as to source type and size. There are included in the proposed standard exceptions to this approach. Because of the substantial number of fuel burning equipment units that will be subject to the RACT limits, the proposed standard includes specific RACT limits for this source type; however, the standard contains administrative mechanisms to allow the owner to demonstrate to the board that the presumptive RACT limits are not appropriate for his facility and recommend other limits. These specific requirements, once determined, would be enforced through an operating permit issued by the board for all source types including fuel burning equipment units. The initial analysis and impact assessment by the department indicates the following impact upon the various facility types affected.

For sources of NOX in the Richmond area, the cost to meet expected RACT limits for the fuel burning equipment units at the four utility plants is estimated to be about $20.5 million in annualized costs for about a 15-year period, to include about $102.5 million in capital costs. The cost to meet the expected RACT limits for the fuel burning equipment units at the nine industrial plants is estimated to be about $2.4 million in annualized costs for about a 15-year period, to include about $12 million in capital costs. The impact upon the process combustion units and one adipic acid plant is expected to be minimal because the facilities are currently able to meet expected RACT limits with existing control equipment. For sources of NOX in the Northern Virginia area, the cost to meet expected RACT limits for the fuel burning equipment units at the three utility plants is estimated to be about $11.1 million in annualized costs for about a 15-year period, to include about $55.5 million in capital costs. The cost to meet the expected RACT limits for the fuel burning equipment units at the eight industrial plants and government facilities is estimated to be about $1.9 million in annualized costs for about a 15-year period, to include about $10 million in capital costs.

b. Costs to agency.

It is not expected that the regulation amendments will result in any cost to the department beyond that currently in the budget.

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

Written comments may be submitted until July 31, 1992, to Director of Program Development, Department of Air Pollution Control, P.O. Box 10089, Richmond, Virginia.

Contact: Robert A. Mann, Director, Program Development, Department of Air Pollution Control, P.O. Box 10089, Richmond, VA 23240, telephone (804) 786-5789.

ALCOHOLIC BEVERAGE CONTROL BOARD

June 8, 1992 - 9:30 a.m. – Open Meeting
June 22, 1992 - 9:30 a.m. – Open Meeting
2901 Hermitage Road, Richmond, Virginia. ♿

A meeting to receive and discuss reports and activities from staff members. Other matters not yet determined.

Contact: Robert N. Swinson, Secretary to the Board, 2901 Hermitage Road, P.O. Box 27491, Richmond, VA 23261, telephone (804) 367-0616.

DEPARTMENT OF AVIATION (VIRGINIA AVIATION BOARD)

June 19, 1992 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Virginia Aviation Board intends to repeal existing regulations entitled: **VR 165-01-02. Rules and Regulations of the Virginia Aviation Board Governing the Licensing of Airmen, Aircraft and Airports, and the Operation of Aircraft and Airports in the State of Virginia,** and promulgate new regulations entitled: **VR 165-01-02:1. Regulations Governing the Licensing and Operation of Airports and Aircraft and Obstructions to Airspace in the Commonwealth of Virginia.** The proposed regulations address topical aviation areas in Virginia for the protection and enhancement of safe and efficient air transportation in the Commonwealth.

Statutory Authority: § 5.1-2 of the Code of Virginia.

Written comments may be submitted until June 19, 1992.

Contact: Keith F. McCrea, AICP, Aviation Planner, 4508 S. Laburnum Avenue, Richmond, VA 23235, telephone (804) 786-1365 or toll-free 1-800-292-1034.

BOARD FOR BARBERS

† **June 8, 1992 - 9 a.m.** – Open Meeting
Department of Commerce, 3600 West Broad Street, 5th Floor, Richmond, Virginia. ♿

A meeting to (i) review applications; (ii) review correspondence; (iii) review enforcement cases; and (iv) conduct routine board business.

Contact: Roberta L. Banning, Assistant Director, 3600 W. Broad Street, Richmond, VA 23230-4917, telephone (804) 367-8590.

CHESAPEAKE BAY LOCAL ASSISTANCE BOARD

June 4, 1992 - 10 a.m. – Open Meeting
General Assembly Building, Senate Room B, 9th and Broad Streets, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

The board will approve local assistance grants for fiscal year 1993 and conduct general business, including review of local Chesapeake Bay Preservation Area programs. Public comment will be heard in the meeting. A tentative agenda will be available from the Chesapeake Bay Local Assistance Department by May 28, 1992.

Contact: Receptionist, Chesapeake Bay Local Assistance Department, 805 E. Broad St., Suite 701, Richmond, VA 23219, telephone (804) 225-3440 or toll-free 1-800-243-7229/TDD ☎

Central Area Review Committee

June 8, 1992 - 10 a.m. – Open Meeting
June 22, 1992 - 10 a.m. – Open Meeting
General Assembly Building, Senate Room B, 9th and Broad Streets, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

The committee will review Chesapeake Bay Preservation Area Programs for the Central Area. Persons interested in observing should call the Chesapeake Bay Local Assistance Department to verify meeting time, location and schedule. No comments from the public will be entertained at the Review Committee meetings. However, written comments are welcome.

Contact: Receptionist, Chesapeake Bay Local Assistance Department, 805 E. Broad St., Suite 701, Richmond, VA 23219, telephone (804) 225-3440 or toll-free 1-800-243-7229/TDD ☎

Northern Area Review Committee

NOTE: CHANGE IN MEETING DATE AND LOCATION
† **June 11, 1992 - 10 a.m.** – Open Meeting
General Assembly Building, Senate Room A, 9th and Broad Streets, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

NOTE: CHANGE IN MEETING DATE
† **June 23, 1992 - 10 a.m.** – Open Meeting
General Assembly Building, Senate Room B, 9th and Broad Streets, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

The committee will review Chesapeake Bay Preservation Area Programs for the Northern Area. Persons interested in observing should call the Chesapeake Bay Local Assistance Department to verify meeting time, location and schedule. No comments

from the public will be entertained at the Review Committee meetings. However, written comments are welcome.

Contact: Receptionist, Chesapeake Bay Local Assistance Department, 805 E. Broad St., Suite 701, Richmond, VA 23219, telephone (804) 225-3440 or toll-free 1-800-243-7229/TDD ☎

Southern Area Review Committee

June 3, 1992 - 10 a.m. – Open Meeting
General Assembly Building, Senate Room B, 9th and Broad Streets, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

Contact: Receptionist, Chesapeake Bay Local Assistance Department, 805 E. Broad St., Suite 701, Richmond, VA 23219, telephone (804) 225-3440 or toll-free 1-800-243-7229/TDD ☎

Regulatory Review Committee and Program Study Group

June 17, 1992 - 10 a.m. – Open Meeting
Monroe Building, 101 North 14th Street, Conference Room D, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

† **June 10, 1992 - 10 a.m.** – Open Meeting
† **June 24, 1992 - 10 a.m.** – Open Meeting
Monroe Building, 101 North 14th Street, Meeting Room B, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

The committee and group will consider issues relating to Chesapeake Bay Preservation Area Designation and Management Regulations, VR 173-02-01. Public comment will be heard at the end of the meeting.

Contact: Receptionist, Chesapeake Bay Local Assistance Department, 805 E. Broad St., Suite 701, Richmond, VA 23219, telephone (804) 225-3440 or toll-free 1-800-243-7229/TDD ☎

COUNCIL ON CHILD DAY CARE AND EARLY CHILDHOOD PROGRAMS

† **June 2, 1992 - 10 a.m.** – Open Meeting
Virginia Housing Development Authority, Conference Room 2, 601 South Belvidere Street, Richmond, Virginia. ♿

A regular business meeting. Public comments will not be received.

Contact: Mary Ellen Verdu, Executive Director, Virginia Council on Child Day Care and Early Childhood Programs, Suite 1116, Washington Building, 1100 Bank Street, Richmond, VA 23219, telephone (804) 371-8603.

CHILD DAY-CARE COUNCIL

† **June 11, 1992 - 9 a.m.** – Open Meeting
Koger Executive Center, West End, Blair Building, Conference Room, 2nd Floor, 1604 Santa Rosa Road, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

A meeting to discuss issues, concerns and programs that impact child care centers, camps, school age programs, and preschool/nursery schools. The public comment period is 1 p.m. Please call ahead of time for possible changes in meeting time.

Contact: Peggy Friedenberg, Legislative Analyst, Office of Governmental Affairs, Department of Social Services, 8007 Discovery Drive, Richmond, VA 23229-8699, telephone (804) 662-9217.

COMPENSATION BOARD

June 25, 1992 - 5 p.m. – Open Meeting
Ninth Street Office Building, Room 913/913A, 9th Floor, 202 North Ninth Street, Richmond, Virginia. ♿ (Interpreter for deaf provided if requested)

A routine meeting to conduct business.

Contact: Bruce W. Haynes, Executive Secretary, P.O. Box 3-F, Richmond, VA 23206-0686, telephone (804) 786-3886.

DEPARTMENT OF CONSERVATION AND RECREATION (BOARD OF)

Board of Conservation and Recreation

† **June 17, 1992 - 10 a.m.** – Open Meeting
Twin Lakes State Park Conference Center, Green Bay, Virginia. ♿

A general business meeting.

Contact: Karen Spencer, Executive Secretary, Department of Conservation and Recreation, 203 Governor St., Suite 302, Richmond, VA 23219, telephone (804) 786-6124 or (804) 786-2121/TDD ☎

Falls of the James Scenic River Advisory Board

† **June 19, 1992 - Noon** – Open Meeting
Planning Commission Conference Room, Fifth Floor City Hall, Richmond, Virginia.

A meeting to review river issues and programs.

Contact: Richard G. Gibbons, Environmental Program Manager, Department of Conservation and Recreation, 203 Governor St., Suite 326, Richmond, VA 23219, telephone (804) 786-4132 or (804) 786-2121/TDD ☎

Recreation in the Juvenile Justice System Advisory Board

† **June 5, 1992 - 9 a.m.** – Open Meeting
Peaks of Otter Lodge, P.O. Box 489, Bedford, Virginia. ♿

A meeting to review progress of implementation of therapeutic recreation services in juvenile detention homes in Virginia.

Contact: Kathy Hamilton Brown, Therapeutic Recreation Specialist, Department of Conservation and Recreation, Division of Planning and Recreation Resources, 203 Governor St., Suite 326, Richmond, VA 23219, telephone (804) 371-0348 or (804) 786-2121/TDD ☎

Virginia Cave Board

† **June 6, 1992 - 12:30 p.m.** – Open Meeting
State Capitol Building, Senate Room 4, Richmond, Virginia. ♿

Third and final meeting of the 1991-1992 Virginia Cave Board. This meeting will address old and new business relating to cave and karst issues of management, protection, research and inventory.

Contact: Lawrence R. Smith, Natural Area Program Manager, 1500 East Main Street, Main Street Station, Suite 312, Richmond, VA 23219, telephone (804) 786-7951.

Virginia Soil and Water Conservation Board

† **June 18, 1992 - 9 a.m.** – Open Meeting
Colonial Farm Credit Office Building, 6526 Mechanicsville Turnpike, Mechanicsville, Virginia.

A regular business meeting.

Contact: Linda J. Cox, Administrative Assistant, Virginia Department of Conservation and Recreation, 203 Governor St., Suite 206, Richmond, VA 23219, telephone (804) 786-2152.

BOARD FOR CONTRACTORS

Complaints Committee

† **June 24, 1992 - 9 a.m.** – Open Meeting
3600 West Broad Street, 5th Floor, Conference Room 1, Richmond, Virginia.

A meeting to review and consider complaints filed by consumers against licensed contractors and to review reports from informal fact-finding conferences.

Contact: A.R. Wade, Assistant Director, Investigation and Adjudication, 3600 West Broad Street, 5th Floor, Richmond, VA 23230, telephone (804) 367-0136.

BOARD OF CORRECTIONS

June 17, 1992 - 10 a.m. – Open Meeting
6900 Atmore Drive, Board of Corrections Board Room, Richmond, Virginia. ♿

A regular monthly meeting to consider such matters as may be presented to the board.

Contact: Mrs. Vivian Toler, Secretary to the Board, 6900 Atmore Drive, Richmond, VA 23225, telephone (804) 674-3262.

BOARD FOR COSMETOLOGY

† **June 22, 1992 - 9 a.m.** – Open Meeting
Department of Commerce, 3600 W. Broad Street, Richmond, Virginia.

A general business meeting.

† **June 23, 1992 - 9 a.m.** – Open Meeting
Department of Commerce, 3600 W. Broad Street, Richmond, Virginia.

Cosmetology examination cut score study. Most of the meeting will be held in executive session.

Contact: Demetra Y. Kontos, Assistant Director, Board for Cosmetology, 3600 West Broad Street, Richmond, VA 23230, telephone (804) 367-2175.

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June 20, 1992 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board for Cosmetology intends to adopt regulations entitled **VR 235-01-03. Nail Technician Regulations.** The purpose of the proposed regulations is to protect the health and safety of those citizens obtaining manicures, pedicures or artificial nail services from disease or unsanitary practices by requiring the licensure of nail technicians, nail salons and those schools teaching these techniques. In licensing this profession, its practitioners are held to uniform standards for entry and conduct which is subject to disciplinary action by the Board for Cosmetology.

The regulations contain standards for entry into the profession as a nail technician, nail salon and nail school. In order to obtain a license as a nail technician one must complete 150 hours of education and pass a written and practical examination. Nail salons shall provide a current address and other information. Nail schools shall provide a copy of their proposed curriculum for approval by the board before licensure. The regulations also set forth standards for

renewal, and standards of sanitary practice and discipline.

Statutory Authority: §§ 54.1-201, 54.1-202, 54.1-1200 and 54.1-1202 B of the Code of Virginia.

Written comments may be submitted until June 20, 1992.

Contact: Demetra Y. Kontos, Assistant Director, Board for Cosmetology, 3600 West Broad Street, Richmond, VA 23230, telephone (804) 367-2175.

CRIMINAL JUSTICE SERVICES BOARD

Criminal Justice Information Systems

† **June 11, 1992 - 10 a.m.** – Open Meeting
Governor's Cabinet Conference Room, 6th Floor, Ninth Street Office Building, 9th and Grace Streets, Richmond, Virginia. ♿

A meeting to discuss projects and business of the committee.

Contact: Paula J. Scott, Executive Assistant, Department of Criminal Justice Services, 805 East Broad Street, Richmond, Virginia 23219, telephone (804) 786-4000.

BOARD OF DENTISTRY

June 20, 1992 - 8 a.m. – Open Meeting
Wytheville Community College, Wytheville, Virginia. ♿

Informal conferences. No public testimony will be received.

Contact: Nancy Taylor Feldman, Executive Director, 1601 Rolling Hills Drive, Richmond, VA, telephone (804) 662-9906.

STATE EDUCATION ASSISTANCE AUTHORITY

June 5, 1992 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Education Assistance Authority intends to amend existing regulations entitled **VR 275-01-1. Regulations Governing Virginia Administration of the Federally Guaranteed Student Loan Programs Under Title IV Part B of the Higher Education Act.** The purpose of the proposed amendments is to update and clarify the administration of the Title IV Part B Loan Programs.

Statutory Authority: § 23-38.64 of the Code of Virginia.

Written comments may be submitted until June 5, 1992, to Marvin L. Ragland, Jr., 411 E. Franklin Street, Richmond, VA 23219.

Contact: Lyn Hammond or Sherry Scott, Policy Analyst, 411 E. Franklin Street, Richmond, VA 23219, telephone (804) 775-4626, 775-4071 or toll-free 1-800-792-5626.

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June 5, 1992 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Education Assistance Authority intends to amend existing regulations entitled **VR 275-02-1. Regulations Governing the Edvantage Loan Program.** The purpose of the proposed amendments is to update and clarify the administration of the Edvantage Loan Program.

Statutory Authority: §§ 23-30.42, 23-38.33:1 and 23-38.64(2) of the Code of Virginia.

Written comments may be submitted until June 5, 1992, to Marvin L. Ragland, Jr., 411 E. Franklin Street, Richmond, VA 23219.

Contact: Lyn Hammond or Sherry Scott, Policy Analyst, 411 E. Franklin Street, Richmond, VA 23219, telephone (804) 775-4626, 775-4071 or toll-free 1-800-792-5626.

DEPARTMENT OF EDUCATION (STATE BOARD OF)

June 24, 1992 - 8 a.m. – Open Meeting
† **July 30, 1992 - 8 a.m.** – Open Meeting
James Monroe Building, 101 North Fourteenth Street, Conference Rooms D and E, Richmond, Virginia. ♿
(Interpreter for deaf provided if requested)

The Board of Education and the Board of Vocational Education will hold a regularly scheduled meeting. Business will be conducted according to items listed on the agenda. The agenda is available upon request. Public comment will not be received at the meeting.

Contact: Dr. Margaret Roberts, Executive Director, State Department of Education, P.O. Box 6-Q, Richmond, VA 23216, telephone (804) 225-2540.

STATE COUNCIL OF HIGHER EDUCATION FOR VIRGINIA

† **June 9, 1992 - 9 a.m.** – Open Meeting
University of Virginia in the Rotunda, Richmond, Virginia.

A general business meeting. For more information contact the Council.

Contact: Anne Pratt, Associate Director, 101 North Fourteenth Street, 9th Floor, Monroe Building, Richmond, VA 23219, telephone (804) 225-2632.

LOCAL EMERGENCY PLANNING COMMITTEE - CITY OF ALEXANDRIA

June 10, 1992 - 6 p.m. – Open Meeting
Alexandria Sanitation Authority, 835 South Payne Street, Alexandria, Virginia. ♿

A meeting with committee members and facility emergency coordinators to conduct business in accordance with SARA Title III, Emergency Planning and Community Right-to-Know Act of 1986.

Contact: Charles W. McRorie, Emergency Preparedness Coordinator, 900 Second Street, Alexandria, VA 22312, telephone (703) 838-3825 or (703) 838-5056/TDD ☎

LOCAL EMERGENCY PLANNING COMMITTEE - CHESTERFIELD COUNTY

June 4, 1992 - 5:30 p.m. – Open Meeting
Chesterfield County Administration Building, 10001 Ironbridge Road, Chesterfield, Virginia. ♿

A meeting to meet requirements of Superfund Amendment and Reauthorization Act of 1986.

Contact: Linda G. Furr, Assistant Emergency Services, Chesterfield Fire Department, P.O. Box 40, Chesterfield, VA 23832, telephone (804) 748-1236.

LOCAL EMERGENCY PLANNING COMMITTEE - PRINCE WILLIAM COUNTY, MANASSAS CITY, AND MANASSAS PARK CITY

June 15, 1992 - 1:30 p.m. – Open Meeting
1 County Complex Court, Potomac Conference Room, Prince William, Virginia. ♿

A multi-jurisdictional local emergency planning committee to discuss issues related to hazardous substances in the jurisdictions. SARA Title III provisions and responsibilities for hazardous material emergency response planning.

Contact: John E. Medici, Hazardous Materials Officer, 1 County Complex Court, Internal Zip MC470, Prince William, VA 22192, telephone (703) 792-6800.

VIRGINIA FIRE SERVICES BOARD

† **June 19, 1992 - 9 a.m.** – Open Meeting
Ramada Inn, Duffield, Virginia.

A regular meeting to discuss fire training and fire policies. The meeting is open to the public for their comments and input.

Contact: Ann J. Bales, Executive Secretary Senior, 2807 Parham Road, Richmond, VA 23294, telephone (804) 527-4236.

Fire/EMS Training and Education Committee

† **June 18, 1992 - 1 p.m.** – Open Meeting
Ramada Inn, Duffield, Virginia.

A meeting to discuss fire training and fire policies. The meeting is open to the public for their comments and input.

Contact: Ann J. Bales, Executive Secretary Senior, 2807 Parham Road, Richmond, VA 23294, telephone (804) 527-4236.

Fire Prevention and Control Committee

† **June 18, 1992 - 9 a.m.** – Open Meeting
Ramada Inn, Duffield, Virginia.

A meeting to discuss fire training and fire policies. The meeting is open to the public for their comments and input.

Contact: Ann J. Bales, Executive Secretary Senior, 2807 Parham Road, Richmond, VA 23294, telephone (804) 527-4236.

Legislative/Liaison Committee

† **June 18, 1992 - 1 p.m.** – Open Meeting
Ramada Inn, Duffield, Virginia.

A meeting to discuss fire training and fire policies. The meeting is open to the public for their comments and input.

Contact: Ann J. Bales, Executive Secretary Senior, 2807 Parham Road, Richmond, VA 23294, telephone (804) 527-4236.

BOARD FOR GEOLOGY

June 4, 1992 - 10 a.m. – Open Meeting
Department of Commerce, 3600 West Broad Street, Conference Room 1, Richmond, Virginia. ♿

June 5, 1992 - 10 a.m. – Open Meeting
Department of Commerce, 3600 West Broad Street, Conference Room 1, Richmond, Virginia. ♿

A general board meeting.

Contact: Nelle P. Hotchkiss, Assistant Director, 3600 W.

Broad Street, Richmond, VA 23230, telephone (804) 367-8595 or (804) 367-9753/TDD ☎

VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment

DEPARTMENT OF HEALTH (STATE BOARD OF)

† **June 9, 1992 - 7 p.m.** – Informal Dinner
Washington/Dulles Airport Marriott, 333 Service Road, Chantilly, Virginia. ♿ (Interpreter for deaf provided if requested)

Informal dinner.

† **June 10, 1992 - 9 a.m.** – Open Meeting
Washington/Dulles Airport Marriott, 333 Service Road, Chantilly, Virginia. ♿ (Interpreter for deaf provided if requested)

Worksession.

† **June 10, 1992 - 1 p.m.** – Open Meeting
Washington/Dulles Airport Marriott, 333 Service Road, Chantilly, Virginia. ♿ (Interpreter for deaf provided if requested)

A business meeting

Contact: Susan R. Rowland, Assistant to the Commissioner, P.O. Box 2448, Richmond, VA 23218, telephone (804) 786-3561.

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June 5, 1992 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Board of Health intends to adopt regulations entitled: **VR 355-34-400. Alternative Discharging Sewage Treatment Regulations for Individual Single Family Dwellings.** These regulations govern the construction and operation of sewage treatment systems serving individual, single family homes with flows of 1,000 gallons per day or less.

Statutory Authority: §§ 32.1-12, 32.1-163 and 32.1-164 of the Code of Virginia.

Written comments may be submitted until June 5, 1992.

Contact: Donald J. Alexander, Director, Bureau of Sewage and Water, P.O. Box 2448, Richmond, VA 23218, telephone (804) 786-3559.

BOARD OF HEALTH PROFESSIONS

Compliance and Discipline Committee

Subcommittee on Board Member Complaint Adjudication

† **June 10, 1992 - 8:30 a.m.** – Open Meeting
Department of Health Professions, 1601 Rolling Hills Drive, Conference Room 4, Richmond, Virginia. ♿

A meeting to review and revise a draft report to be presented to the full board for approval at the July 21 meeting.

Contact: Richard D. Morrison, Executive Director, 1601 Rolling Hills Drive, Richmond, VA 23229, telephone (804) 662-9904 or (804) 662-7197/TDD ☎

VIRGINIA HEALTH SERVICES COST REVIEW COUNCIL

June 23, 1992 - 9:30 a.m. – Open Meeting
Blue Cross/Blue Shield of Virginia, 2015 Staples Mill Road, Richmond, Virginia. ♿

A regular monthly meeting.

Contact: Kim Schulte Barnes, Information Officer, 805 East Broad St., 6th Floor, Richmond, VA 23219, telephone (804) 786-6371/TDD ☎

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July 20, 1992 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Virginia Health Services Cost Review Council intends to amend regulations entitled: **VR 370-01-001. Rules and Regulations of the Virginia Health Services Cost Review Council.** The proposed regulatory change to §§ 6.1 and 6.2 of the regulations would allow health care institutions which neither receive Medicare nor Medicaid reimbursement for patients to develop their own methodology to ascertain nursing home costs and to eliminate the requirement that these facilities utilize the allocation methodology used for cost reports filed with the Virginia Department of Medical Assistance Services or for the Medicare program.

Statutory Authority: §§ 9-158 and 9-164 of the Code of Virginia.

Written comments may be submitted until July 20, 1992, to G. Edward Dalton, Virginia Health Services Cost Review Council, 805 E. Broad St., Richmond, VA 23219.

Contact: John A. Rupp, Executive Director, 805 E. Broad St., 6th Floor, Richmond, VA 23219, telephone (804) 786-6371. ⅓

DEPARTMENT OF HISTORIC RESOURCES (BOARD OF)

† **June 17, 1992 - 9 a.m.** – Open Meeting
City Council Chambers, Roanoke City Hall, 215 Church Avenue, S.W., Roanoke, Virginia. ♿ (Interpreter for deaf provided if requested)

A joint meeting of the State Review Board and Historic Resources Board to consider the following properties for the Virginia Landmarks Register and the National Register of Historic Places:

1. Blandy Experimental Farm, Clarke County.
2. Virginia Episcopal School, Lynchburg.
3. Dublin Historic District, Pulaski County.
4. Tastee 29 Diner, City of Fairfax.

Contact: Margaret Peters, Information Director, Department of Historic Resources, 221 Governor Street, Richmond, VA 23219, telephone (804) 786-3143 or (804) 786-1934/TDD ☎

June 18, 1992 - 2 p.m. – Open Meeting
Department of Historic Resources, Board Room, 221 Governor Street, Richmond, Virginia.

A meeting to receive views and comments and to answer questions of the public on the department's intent to consider adopting VR 390-01-01:2, Public Participation Guidelines.

Contact: H. Bryan Mitchell, Deputy Director, Department of Historic Resources, 221 Governor Street, Richmond, VA 23219, telephone (804) 786-3143 or (804) 786-1934/TDD ☎

HOPEWELL INDUSTRIAL SAFETY COUNCIL

June 2, 1992 - 9 a.m. – Open Meeting
July 7, 1992 - 9 a.m. – Open Meeting
Hopewell Community Center, Second & City Point Road, Hopewell, Virginia. ♿ (Interpreter for deaf provided if requested)

Local Emergency Preparedness Committee meeting on Emergency Preparedness as required by SARA Title III.

Contact: Robert Brown, Emergency Services Coordinator, 300 North Main Street, Hopewell, VA 23860, telephone (804) 541-2298.

VIRGINIA HOUSING DEVELOPMENT AUTHORITY

† **June 16, 1992 - 11 a.m.** – Open Meeting
601 S. Belvidere Street, Richmond, Virginia. ♿

A regular meeting of the Board of Commissioners to (i) review and, if appropriate, approve the minutes from the prior monthly meeting; (ii) consider for approval and ratification mortgage loan commitments under its various programs; (iii) review the authority's operations for the prior month; (iv) consider, and if appropriate, approve proposed amendments to the Rules and Regulations for Allocation of Elderly and Disabled Low-Income Housing Tax Credits; and (v) consider such other matters and take such other actions as it may deem appropriate. Various committees of the Board of Commissioners may also meet before or after the regular meeting and consider matters within their purview. The planned agenda of the meeting will be available one week prior to the date of the meeting.

Contact: J. Judson McKellar, Jr., General Counsel, Virginia Housing Development Authority, 601 S. Belvidere Street, Richmond, VA 23220, telephone (804) 782-1986.

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† **June 12, 1992** – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Virginia Housing Development Authority intends to amend regulations entitled: **VR 400-02-0016. Rules and Regulations for Allocation of Elderly and Disabled Low-Income Housing Tax Credits.** The purpose of this action is to amend the rules and regulations for allocation or elderly and disabled low-income housing tax credits by making changes relating to housing structures that have no comparable units in the same property, by modifying eligibility requirements, by amending certain definitions and by making other clarifying changes and technical corrections.

STATEMENT

Basis: Sections 36-55.30:3 and 58.1-339 of the Code of Virginia.

Substance and Issues: The proposed changes to the rules and regulations for allocation of elderly and disabled low-income housing tax credits attached hereto accomplish the following:

1. Throughout the regulations the term "owner" is substituted for "applicant."

2. The definition of "disabled" is changed to "disability" and conformed to the definition of the U.S. Department of Housing and Urban Development under its section 8 program by requiring that the disability be "of permanent duration" (i.e., last for a period of at least one year).

3. The definitions of a "disabled person," disabled household," "elderly household" and "income eligible elderly or disabled person or household" are deleted, and the definitions "elderly tenant," "eligible tenant," "person with a disability," "tenant" and "tenant with a disability" are added; also, the requirement that the elderly person be either the head of household or the spouse of the head of household is deleted.

4. The 1992 Session of the General Assembly amended the tax credit legislation to permit tax credits for single family homes and other types of structures having no comparable units in the same property. The proposed amendments modify the existing regulation to conform with such statutory amendments and provide for the manner of determining the amount of rent reduction for such units - i.e., generally, the rent most recently charged for the unit within the preceding year (or, if no such rental history exists, the HUD fair market rent) minus the rent (defined as "tax credit rent") charged to the eligible tenant.

5. Under the proposed amendments, a limit of 150% of the HUD fair market rent is placed on the rent (defined as "market rent") which is used in calculating the amount of the rent reduction.

6. The definition of income is changed to exclude a roommate's income only if such roommate lives with the eligible tenant for "the primary purpose of providing care." Also, a provision is added to consider as income any payments by third parties (i.e., Community Service Boards and family members) to or on behalf of the tenant.

7. Language is added to permit units receiving rental subsidies to be eligible under the program and to clarify that subsidized units are to be compared with other subsidized units to determine market rent for the purpose of calculating the rent reduction.

8. Language is added to clarify that, although tax credits cannot be allocated for the rental of land only, credits are available for mobile homes and lots rented together.

9. Language is added to provide that, in order to satisfy the statutory requirement that an owner be engaged in the business of the rental of dwelling units, he must intend to report income and related expenses from the tax credit unit for federal income tax purposes.

10. The requirement that resident eligibility information be submitted by the owner at the end of the year is modified so that the information must be submitted at the time the resident is determined by the owner to be eligible.

11. A provision is added to clarify that the period during which tax credits may be claimed commences upon the initial occupancy of the unit by an eligible tenant subsequent to the authority's allocation of the tax credit units (or, if the unit is occupied for the first day of the month in which such allocation is made, upon such first day of the month).

12. The proposed regulations provide that, in order to be eligible, a dwelling unit must contain separate and complete facilities for living, sleeping, eating, cooking and sanitation.

Impact: The authority expects that the amendments will result in an additional 300 persons being served under the program. The authority does not expect that any significant costs will be incurred for the implementation of and compliance with the amendments.

Statutory Authority: §§ 36-55.30:3 and 58.1-339 of the Code of Virginia.

Written comments may be submitted until June 12, 1992.

Contact: J. Judson McKellar, Jr., General Counsel, Virginia Housing Development Authority, 601 S. Belvidere Street, Richmond, VA 23220, telephone (804) 782-1986.

CENTER FOR INNOVATIVE TECHNOLOGY

Review Committee

† **June 10, 1992 - 10 a.m.** – Open Meeting
The Center for Innovative Technology, Herndon, Virginia.

A meeting to discuss and approve a plan and methodology for conducting "a review of the performance of the CIT and future funding levels and sources." The meeting will also include invited guest speakers. This meeting will be followed by a public forum in the auditorium at approximately 1:30 p.m. This forum will provide the Review Committee public comment in preparation for the committee's "plan to provide guidance for maximizing the center's potential." The Review Committee will report its findings and recommendations to the Governor and General Assembly.

Persons wishing to speak should contact Kim Moore, Department of Planning and Budget, Ninth Street Office Building, P.O. Box 1422, Richmond, VA 23211, telephone (804) 786-6233.

Contact: Kim McGauthey, Department of Planning and Budget, Ninth Street Office Building, P.O. Box 1422, Richmond, VA 23211, telephone (804) 786-8856 or Terry Atkinson, JLARC, Suite 1100, General Assembly Building, Capitol Square, Richmond, VA 23219, telephone (804) 786-1258.

DEPARTMENT OF LABOR AND INDUSTRY

July 16, 1992 - 10 a.m. – Public Hearing
General Assembly Building, House Room C, 910 Capitol Street, Richmond, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Apprenticeship Council intends to amend regulations entitled: **VR 425-01-26. Regulations Governing the Administration of Apprenticeship Programs in the Commonwealth of Virginia.** This amendment provides criteria and procedure for deregistration of apprenticeship programs.

Statutory Authority: § 40.1-118 of the Code of Virginia.

Written comments may be submitted until July 6, 1992.

Contact: Robert S. Baumgardner, Director, Apprenticeship Division, Department of Labor and Industry, 13 South Thirteenth Street, Richmond, VA 23219, telephone (804) 786-2381.

July 16, 1992 - Immediately following public hearing beginning at 10 a.m. – Open Meeting
General Assembly Building, House Room C, 910 Capitol Street, Richmond, Virginia. ♿

A regular quarterly meeting.

Contact: Robert S. Baumgardner, Director, Apprenticeship Division, Department of Labor and Industry, 13 South Thirteenth Street, Richmond, VA 23219, telephone (804) 786-2381.

Safety and Health Codes Board

† **June 9, 1992 - 10 a.m.** – Open Meeting
General Assembly Building, House Room D, 910 Capitol Street, Richmond, Virginia. ♿

The agenda of the board will include the following: (i) Process Safety Management of Highly Hazardous Chemicals; Explosives and Blasting Agents; Final Rule; (ii) Extension of Administrative Stay to Occupational Exposure to Asbestos, Tremolite, Anthophyllite and Actinolite.

Contact: John J. Crisanti, Director, Office of Enforcement Policy, Department of Labor and Industry, 13 South Thirteenth Street, Richmond, VA 23219, telephone (804) 786-2384.

LIBRARY BOARD

June 23, 1992 - 9:30 a.m. – Open Meeting
Virginia State Library and Archives, 3rd Floor, Supreme Court Room, 11th Street at Capitol Square, Richmond, Virginia. ♿

A meeting to discuss administrative matters of the Virginia State Library and Archives.

Contact: Jean H. Taylor, Secretary to State Librarian, Virginia State Library and Archives, 11th Street at Capitol Square, Richmond, VA 23219, telephone (804) 786-2332.

STATE COUNCIL ON LOCAL DEBT

† **June 17, 1992 - 11 a.m.** – Open Meeting
101 North 14th Street, James Monroe Building, 3rd Floor, Treasury Board Conference Room, Richmond, Virginia. ♿

A regular meeting subject to cancellation unless there are action items requiring the council's consideration. Persons interested in attending should call one week prior to meeting date to ascertain whether or not the meeting is to be held as scheduled.

Contact: Art Bowen, Senior Debt Analyst, Department of the Treasury, P.O. Box 6-H, Richmond, VA 23215, telephone (804) 225-4929.

STATE LOTTERY DEPARTMENT (STATE LOTTERY BOARD)

July 27, 1992 - 10 a.m. – Public Hearing
2201 West Broad Street, Richmond, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Lottery Board intends to amend regulations entitled: **VR 447-01-2. Administration Regulations.** These proposed amendments will conform to legislative intent and make technical and housekeeping changes.

Statutory Authority: § 58.1-4007 of the Code of Virginia.

Written comments may be submitted until July 27, 1992.

Contact: Barbara L. Robertson, Staff Officer, 2210 W. Broad Street, Richmond, VA 23220, telephone (804) 367-9433.

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July 27, 1992 - 10 a.m. – Public Hearing
2201 West Broad Street, Richmond, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Lottery Board intends to amend regulations entitled: **VR 447-02-1. Instant Game Regulations.** These amendments promulgate emergency regulations regarding prize payments, conform to legislative intent, and address housekeeping and technical changes.

Statutory Authority: § 58.1-4007 of the Code of Virginia.

Written comments may be submitted until July 27, 1992.

Contact: Barbara L. Robertson, Staff Officer, 2210 W. Broad Street, Richmond, VA 23220, telephone (804) 367-9433.

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July 27, 1992 - 10 a.m. – Public Hearing
2201 West Broad Street, Richmond, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Lottery Board intends to amend regulations entitled: **VR 447-02-2. On-Line Game Regulations.** These amendments promulgate emergency subscription regulations, conform to legislative intent, and make housekeeping and technical changes.

Statutory Authority: § 58.1-4007 of the Code of Virginia.

Written comments may be submitted until July 27, 1992.

Contact: Barbara L. Robertson, Staff Officer, 2210 W. Broad Street, Richmond, VA 23220, telephone (804) 367-9433.

ADVISORY COMMISSION ON MAPPING, SURVEYING AND LAND INFORMATION SYSTEMS

June 18, 1992 - 10 a.m. – Open Meeting
1100 Bank Street, 9th Floor Conference Room, Richmond, Virginia.

Final meeting of the Advisory Commission.

Contact: Chuck Tyger, Chief Engineer, Systems and Software Management, Council on Information Management, 1100 Bank Street, Suite 901, Richmond, VA 23219, telephone (804) 225-3622 or (804) 225-3624/TDD

MARINE RESOURCES COMMISSION

June 23, 1992 - 9:30 a.m. – Open Meeting
July 28, 1992 - 9:30 a.m. – Open Meeting
2600 Washington Avenue, 4th Floor, Room 403, Newport News, Virginia. (Interpreter for deaf provided upon request)

The commission will hear and decide marine environmental matters at 9:30 a.m.: permit applications for projects in wetlands, bottom lands, coastal primary sand dunes and beaches; appeals of local wetland board decisions; policy and regulatory issues.

The commission will hear and decide fishery management items: regulatory proposals, fishery management plans, fishery conservation issues, licensing, shellfish leasing.

Meetings are open to the public. Testimony is taken under oath from parties addressing agenda items on permits and licensing. Public comments are taken on resource matters, regulatory issues, and items scheduled for public hearing. The commission is empowered to promulgate regulations in the areas of marine environmental management and marine fishery management.

Contact: Cathy W. Everett, Secretary to the Commission, P.O. Box 756, Room 1006, Newport News, VA 23607, telephone (804) 247-8088, toll-free 1-800-541-4646 or (804) 247-2292/TDD

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (BOARD OF)

† **June 8, 1992 - 9 a.m.** – Open Meeting
Board Room, Suite 1300, 600 East Broad Street, Richmond, Virginia.

A meeting to discuss medical assistance services and issues pertinent to the board. The board will hear presentations from medical ethicists on the ethical issues involved in organ and tissue transplantation.

Contact: Patricia A. Sykes, Policy Analyst, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 786-7958 or 1-800-343-0634/TDD

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July 17, 1992 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board of Medical Assistance Services intends to amend regulations entitled: **VR 460-02-3.1400. Methods of Providing Transportation.** The purpose of the proposed action is to discontinue the prior authorization requirement for nonemergency transportation for recipients to and from other medical appointments.

Statutory Authority: § 32.1-325 of the Code of Virginia.

Written comments may be submitted July 17, 1992, to C. Mack Brankley, Director, Division of Client Services, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219.

Contact: Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23229, telephone (804) 786-7933.

Drug Utilization Review Board

† **June 18, 1992 - 3 p.m.** – Open Meeting
600 East Broad Street, Suite 300, Richmond, Virginia.

A regular meeting to conduct routine business.

Contact: Carol B. Pugh, DUR Program Consultant, Division of Quality Care Assurance, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 786-3820.

BOARD OF MEDICINE

July 6, 1992 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board of Medicine intends to amend regulations entitled: **VR 465-04-01. Regulations Governing the Practice of Respiratory Therapy Practitioners.** The proposed amendment is to establish biennial certification renewal to occur in the therapists' birth month each odd-numbered year, and to make grammatical corrections to be consistent with the language of the Code of Virginia.

Statutory Authority: §§ 54.1-2400 and 54.1-2954 of the Code of Virginia.

Written comments may be submitted until July 6, 1992, to Hilary H. Connor, M.D., Executive Director, Board of Medicine, 1601 Rolling Hills Dr., Richmond, VA 23229.

Contact: Eugenia K. Dorson, Deputy Executive Director, 1601 Rolling Hills Dr., Richmond, VA 23229, telephone (804) 662-9923.

Credentials Committee

June 20, 1992 - 8 a.m. – Open Meeting
Department of Health Professions, Board Room 3, 1601 Rolling Hills Drive, Richmond, Virginia. ♿

A meeting to (i) conduct general business; (ii) interview and review medical credentials of applicants applying for licensure in Virginia, in open and executive session; and (iii) discuss any other items which may come before the committee. Public comments will not be received.

Contact: Eugenia K. Dorson, Deputy Executive Director, 1601 Rolling Hills Drive, Richmond, VA 23229, telephone (804) 662-9923.

Informal Conference Committee

† **June 24, 1992 - 9 a.m.** – Open Meeting
The Patrick Henry Hotel, 617 South Jefferson Street, Roanoke, Virginia. ♿

The committee will inquire into allegations that certain practitioners may have violated laws and regulations governing the practice of medicine and other healing arts in Virginia. The committee will meet in open and closed sessions pursuant to § 2.1-344 of the Code of Virginia. Public comment will not be received.

Contact: Karen W. Perrine, Deputy Executive Director, 1601 Rolling Hills Drive, Richmond, VA 23229, telephone (804) 662-9908 or (804) 662-9943/TDD ☎

Advisory Board on Physical Therapy

July 10, 1992 - 9 a.m. – Open Meeting
Department of Health Professions, Board Room 2, 1601 Rolling Hills Drive, Richmond, Virginia. ♿

A meeting to (i) review regulations, bylaws, and procedure manuals; (ii) receive reports; and (iii) discuss other items which may come before the advisory board. Public comments will be received at the pleasure of the chairperson.

Contact: Eugenia K. Dorson, Deputy Executive Director, 1601 Rolling Hills Drive, Richmond, VA 23229, telephone (804) 662-9925.

Advisory Committee on Physician's Assistants

June 26, 1992 - 10 a.m. – Open Meeting
Department of Health Professions, Board Room 2, 1601 Rolling Hills Drive, Richmond, Virginia. ♿

A meeting to review the public comments on proposed regulations and develop recommendations to the full board for adoption and to review and discuss Senate Bill 192, for the purpose of developing regulations for prescriptive authority for physician's assistants. Public comments may be entertained by the chairman on SB 192 only.

Contact: Eugenia K. Dorson, Deputy Executive Director, 1601 Rolling Hills Drive, Richmond, VA 23229, telephone (804) 662-9925.

DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES (STATE BOARD)

† **June 24, 1992 - 10 a.m.** – Open Meeting
Central Office, James Madison Building, 109 Governor Street, Richmond, Virginia. ♿

A regular monthly meeting. The agenda will be published on June 17 and may be obtained by calling Jane V. Helfrich.

Tuesday: Informal Session - 8 p.m.

Wednesday: Committee Meetings - 9 a.m.

Wednesday: Regular Session - 10 a.m.

See agenda for location.

Contact: Jane V. Helfrich, Board Administrator, State Mental Health, Mental Retardation and Substance Abuse Services Board, P.O. Box 1797, Richmond, VA 23214, telephone (804) 786-3921.

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June 5, 1992 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Mental Health, Mental Retardation and Substance Abuse Services Board intends to adopt regulations entitled: **VR 470-05-02. Regulations Governing Certification of Therapeutic Consultation and Residential Services.** These regulations establish the standards which must be met by individuals and facilities providing therapeutic consultation and residential support services under the Mental Retardation Waiver.

Statutory Authority: §§ 37.1-10, 37.1-179 of the Code of Virginia, and Items 466.F.5 and 478.F.1 of the 1990 Appropriations Act.

Written comments may be submitted until June 5, 1992, to Ben Saunders, Department of Mental Health, Mental Retardation and Substance Abuse Services, P.O. Box 1797, Richmond, VA 23229.

Contact: Rubyjean Gould, Director of Administrative Services, Department of Mental Health, Mental Retardation and Substance Abuse Services, P.O. Box 1797, Richmond, VA 23214, telephone (804) 786-3915.

State Human Rights Committee

† **June 12, 1992 - 9 a.m.** – Open Meeting
Mental Health Services of the Roanoke Valley, Elm Plaza Building, 301 Elm Avenue, S.W., Roanoke, Virginia. ♿

A regular monthly meeting to discuss business relating to human rights issues. Agenda items are listed for the meeting.

Contact: Elsie D. Little, State Human Rights Director, Department of Mental Health, Mental Retardation and Substance Abuse Services, P.O. Box 1797, Richmond, VA 23214, telephone (804) 786-3988.

MIDDLE VIRGINIA BOARD OF DIRECTORS AND THE MIDDLE VIRGINIA COMMUNITY CORRECTIONS RESOURCES BOARD

† **June 4, 1992 - 7 p.m.** – Open Meeting
502 South Main Street #4, Culpeper, Virginia.

From 7 p.m. until 7:30 p.m. the Board of Directors will hold a business meeting to discuss DOC contract, budget, and other related business. Then the CCRB will meet to review cases before for eligibility to participate with the program. It will review the previous month's operation (budget and program related business).

Contact: Lisa Ann Peacock, Program Director, 502 South Main Street #4, Culpeper, VA 22701, telephone (703) 825-4562.

DEPARTMENT OF MINORITY BUSINESS ENTERPRISE

June 19, 1992 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Department of Minority Business Enterprise intends to adopt regulations entitled: **VR 486-01-02. Regulations to Govern the Certification of Minority Business Enterprises.** The proposed regulations will provide rules governing the certification of a business as a bonafide minority business enterprise.

Statutory Authority: § 2.1-64.35:8 of the Code of Virginia.

Written comments may be submitted until June 19, 1992.

Contact: Garland W. Curtis, Deputy Director, Department of Minority Business Enterprise, 200-202 N. 9th Street, 11th Floor, Richmond, VA 23219, telephone (804) 786-5560 or toll-free 1-800-223-0671.

BOARD OF NURSING

Special Conference Committee

† **June 8, 1992 - 8:30 a.m.** – Open Meeting
† **June 9, 1992 - 8:30 a.m.** – Open Meeting
Department of Health Professions, Conference Room 3, 1601 Rolling Hills Drive, Richmond, Virginia. ♿
(Interpreter for deaf provided upon request)

A meeting to conduct informal conferences with licensees to determine what, if any, action should be recommended to the Board of Nursing.

Public comment will not be received.

Contact: Corrinne F. Dorsey, Executive Director, 1601 Rolling Hills Drive, Richmond, VA 23229, telephone (804) 662-9909 or (804) 662-7197/TDD ☎

BOARD OF NURSING HOME ADMINISTRATORS

June 4, 1992 - 8:30 a.m. – Open Meeting
1601 Rolling Hills Drive, Richmond, Virginia. ♿

A board meeting and formal conferences.

Contact: Meredyth P. Partridge, Executive Director, 1601 Rolling Hills Drive, Richmond, VA 23229-5005, telephone (804) 662-9111.

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July 3, 1992 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board of Nursing Home Administrators intends to amend regulations entitled: **VR 500-01-2:1. Regulations of the Board of Nursing Home Administrators.** The board is amending regulations to delete outdated requirements, clarify continuing education requirements, provide an additional route to licensure, and revise reinstatement requirements.

Statutory Authority: §§ 54.1-2400 and 54.1-3101 of the Code of Virginia.

Written comments may be submitted until July 3, 1992.

Contact: Meredyth P. Partridge, Executive Director, 1601 Rolling Hills Drive, Richmond, VA 23229-5005, telephone (804) 662-9111.

VIRGINIA OUTDOORS FOUNDATION

June 1, 1992 - 10:30 a.m. – Open Meeting
Panorama Farms, Albemarle County, Virginia. ♿

A general business meeting.

Contact: Tyson B. VanAuken, Executive Director, 221 Governor Street, Richmond, VA 23219, telephone (804) 786-5539.

BOARD OF PHARMACY

† **June 10, 1992 - 9 a.m.** – Open Meeting
Department of Health Professions, 1601 Rolling Hills Drive, Conference Room #1, Richmond, Virginia.

A meeting to discuss implementation of 1992 legislative changes.

† **June 11, 1992 - 9 a.m.** – Open Meeting
Department of Health Professions, 1601 Rolling Hills Drive, Conference Room #1, Richmond, Virginia.

Formal hearings.

Contact: Scotti W. Milley, Executive Director, Virginia Board of Pharmacy, 1601 Rolling Hills Drive, Richmond, VA 23229, telephone (804) 662-9911.

POLYGRAPH EXAMINERS ADVISORY BOARD

June 23, 1992 - 9 a.m. – Open Meeting
Department of Commerce, 3600 West Broad Street, Richmond, Virginia. ♿

A meeting to administer the polygraph examiners licensing examination to eligible polygraph examiner interns and to consider other matters which may require board action.

Contact: Mr. Geralde W. Morgan, Board Administrator, Department of Commerce, 3600 W. Broad Street, Richmond, VA 23230-4917, telephone (804) 367-8534.

BOARD OF PROFESSIONAL COUNSELORS

June 15, 1992 - 8 a.m. – Open Meeting
June 16, 1992 - 8 a.m. – Open Meeting
June 17, 1992 - 8 a.m. – Open Meeting
June 18, 1992 - 8 a.m. – Open Meeting
Department of Health Professions, 1601 Rolling Hills Drive, Richmond, Virginia.

Oral examinations for professional counselor licensure.

June 18, 1992 - 9 a.m. – Open Meeting
Department of Health Professions, 1601 Rolling Hills Drive, Richmond, Virginia.

Informal conferences.

June 19, 1992 - 9 a.m. – Open Meeting
Department of Health Professions, 1601 Rolling Hills Drive, Richmond, Virginia.

A board meeting to (i) discuss general board business; (ii) respond to committee report; and (iii) conduct regulatory review.

Contact: Evelyn B. Brown, Executive Director or Joyce D. Williams, Administrative Assistant, 1601 Rolling Hills Drive, Richmond, VA 23229-5005, telephone (804) 662-9912.

VIRGINIA PUBLIC TELECOMMUNICATIONS BOARD

† **June 11, 1992 - 10 a.m.** – Open Meeting
Radisson Hotel, 555 East Canal Street, Richmond, Virginia.

A meeting to (i) update Master Plan Policies and Procedures; (ii) approve contracts and grants 1992-93; and (iii) update other items of interest.

Contact: Suzanne J. Piland, Branch Manager, Public Telecommunications Branch, Telemedia Division, 110 South 7th Street, Richmond, VA 23219, telephone (804) 344-5544.

REAL ESTATE APPRAISER BOARD

† **June 16, 1992 - 10 a.m.** – Open Meeting
Department of Commerce, 3600 West Broad Street, Richmond, Virginia.

A general business meeting.

Contact: Demetra Y. Kontos, Assistant Director, Real Estate Appraiser Board, Department of Commerce, 3600 W. Broad Street, Richmond, VA 23230, telephone (804) 367-2175.

REAL ESTATE BOARD

† **June 8, 1992 - 10 a.m.** – Open Meeting
Department of Commerce, Fifth Floor, Conference Room 3, 3600 West Broad Street, Richmond, Virginia.

The board will meet to conduct a formal hearing: File No. 91-01251, Real Estate Board v. Patrick G. Carpenter.

† **June 9, 1992 - 10 a.m.** – Open Meeting
Department of Commerce, Fifth Floor, Conference Room 1, 3600 West Broad Street, Richmond, Virginia.

The board will meet to conduct a formal hearing: File Nos. 92-00220, 91-02090, 92-00074 and 92-01068, Real Estate Board v. Maynard Johnson.

Contact: Gayle Eubank, Hearings Coordinator, Department of Commerce, 3600 W. Broad Street, Fifth Floor, Richmond, VA 23230, telephone (804) 367-8524.

DEPARTMENT OF REHABILITATIVE SERVICES (BOARD OF)

† **June 5, 1992 - 3 p.m.** – Open Meeting
Tidewater Community Rehab Center, 5365 Robin Hood Road, Suite G, Norfolk, Virginia. ♿ (Interpreter for deaf provided upon request)

† **June 8, 1992 - 3 p.m.** – Open Meeting
Brambleton Corporate Center, 3433 Brambleton Avenue, S.W., Roanoke, Virginia. ♿ (Interpreter for deaf provided upon request)

† **June 8, 1992 - 3 p.m.** – Open Meeting
5904 Old Richmond Highway, Suite 400, Alexandria, Virginia. ♿ (Interpreter for deaf provided upon request)

† **June 9, 1992 - 3 p.m.** – Open Meeting
Regional Office Conference Room, 2930 West Broad Street, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

† **June 9, 1992 - 3 p.m.** – Open Meeting
Virginia Highlands Community College, P.O. Box 828, Abingdon, Virginia. ♿ (Interpreter for deaf provided upon request)

† **June 11, 1992 - 3 p.m.** – Open Meeting
Woodrow Wilson Rehabilitation Center, Mary Switzer Building, Fisherville, Virginia. ♿ (Interpreter for deaf provided upon request)

The department is interested in receiving comments from Virginia citizens regarding a draft 1993 plan for vocational rehabilitation services. Citizen input will be incorporated in the refinement of this draft plan and will also be a basis for the development of the 1994 plan. The plan describes the agency's proposed strategies for strengthening and expanding rehabilitation services to Virginians with severe disabilities. The plan also identifies the federal regulations which the agency must comply with in order to receive funding under the Federal Rehabilitation Act.

Contact: Mary Arginteanu, Policy and Planning Supervisor, 4901 Fitzhugh Avenue, P.O. Box 11045, Richmond, VA 23230, telephone (804) 367-0270 or toll-free 1-800-552-5019/TDD ☎

INTERDEPARTMENTAL REGULATION OF RESIDENTIAL FACILITIES FOR CHILDREN

Coordinating Committee

June 19, 1992 - 8:30 a.m. – Open Meeting
Office of the Coordinator, Interdepartmental Regulation, 1603 Santa Rosa Road, Tyler Building, Suite 208, Richmond, Virginia. ♿

A regular meeting to consider such administrative and policy issues as may be presented to the committee. A period for public comment is provided at each meeting.

Contact: John J. Allen, Coordinator, Interdepartmental Regulation, Office of the Coordinator, 8007 Discovery Drive, Richmond, VA 23229-8699, telephone (804) 662-7124.

DEPARTMENT OF SOCIAL SERVICES (BOARD OF)

June 17, 1992 - 2 p.m. – Open Meeting
June 18, 1992 - if necessary - 9 a.m. – Open Meeting
July 15, 1992 - 2 p.m. – Open Meeting
July 16, 1992 - if necessary - 9 a.m. – Open Meeting
Department of Social Services, 8007 Discovery Drive, Richmond, Virginia. ♿

A work session and formal business meeting of the aforementioned board.

Contact: Phyllis Sisk, Staff Specialist, Department of Social Services, 8007 Discovery Drive, Richmond, VA 23229,

telephone (804) 662-9236, toll-free 1-800-552-3431 or 1-800-552-7096/TDD ☎

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June 19, 1992 - 10 a.m. – Public Hearing
Blair Building, Conference Room C, 8007 Discovery Drive, Richmond, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board of Social Services intends to amend regulations entitled: **VR 615-08-1. Virginia Energy Assistance Program.** The purpose of the Virginia Energy Assistance Program is to provide assistance to eligible households to offset the costs of home energy that are excessive in relation to household income and to respond to energy-related, weather-related, and supply shortage emergencies.

The amendments to the crisis assistance component will clarify that routine maintenance such as chimney cleaning and that supplemental heating equipment such as oil tanks and stands will be provided. The second amendment to the crisis assistance component will further clarify the intent to provide fuel to respond to the crisis situation of households who did not receive fuel assistance in the current program year.

Statutory Authority: § 63.1-25 of the Code of Virginia.

Written comments may be submitted until June 19, 1992, to Charlene H. Chapman, Department of Social Services, 8007 Discovery Drive, Richmond, VA.

Contact: Peggy Friedenberg, Legislative Analyst, Department of Social Services, 8007 Discovery Drive, Richmond, VA 23229-8699, telephone (804) 662-9217.

DEPARTMENT OF TRANSPORTATION (COMMONWEALTH TRANSPORTATION BOARD)

June 11, 1992 - 9 a.m. – Public Hearing
Salem District Office, Harrison Avenue, North of Main Street and East of VA 311, Salem, Virginia. ♿ (Interpreter for deaf provided upon request)

A final hearing to receive comments on highway allocations for the coming year and on updating the Six-Year Improvement Program for the Interstate, Primary, and Urban Systems for the Bristol, Salem, Lynchburg, and Staunton Districts, as well as public transit.

† **June 17, 1992 - 2 p.m.** – Open Meeting
Virginia Department of Transportation, Board Room, 1401 East Broad Street, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

A work session of the Commonwealth Transportation Board and the Department of Transportation staff.

Contact: John G. Milliken, Secretary of Transportation, 1401 East Broad Street, Richmond, VA 23219, telephone (804) 786-6670.

June 18, 1992 - 9 a.m. – Public Hearing
Virginia Department of Transportation, Auditorium, 1221 East Broad Street, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

A final hearing to receive comments on highway allocations for the coming year and on updating the Six-Year Improvement Program for the Interstate, Primary, and Urban Systems for the Richmond, Fredericksburg, Suffolk, Culpeper, and Northern Virginia Districts, as well as public transit.

Contact: Mr. Albert W. Coates, Jr., Assistant Commissioner, Virginia Department of Transportation, 1401 East Broad Street, Richmond, VA 23219, telephone (804) 786-9950.

† **June 18, 1992 - 10 a.m.** – Open Meeting
Virginia Department of Transportation, Board Room, 1401 East Broad Street, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

A monthly meeting to vote on proposals presented regarding bids, permits, additions and deletions to the highway system, and any other matters requiring board approval.

Public comment will be received at the outset of the meeting on items on the meeting agenda for which the opportunity for public comment has not been afforded the public in another forum. Remarks will be limited to five minutes. Large groups are asked to select one individual to speak for the group. The board reserves the right to amend these conditions.

Contact: John G. Milliken, Secretary of Transportation, 1401 East Broad Street, Richmond, VA 23219, telephone (804) 786-6670.

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† **August 10, 1992 - 1 p.m.** – Public Hearing
Highway Auditorium, 1221 East Broad Street, Richmond, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Commonwealth Transportation Board intends to amend regulations entitled: **VR 385-01-5. Hazardous Materials Transportation Rules and Regulations at Bridge-Tunnel Facilities.** The Department of Transportation is authorized by §§ 33.1-12(3) and 33.1-49 of the Code of Virginia to regulate use of state highways and the interstate system to protect the safety to traffic. The proposed amendments to the

Hazardous Materials Transportation Manual (i) change the regulations to allow vehicles which use natural gas (or gases with similar properties) as fuel to use the tunnel facilities in the Commonwealth; and (ii) change the regulations pertaining to the conditions under which low-pressure liquid oxygen can be transported through tunnel facilities in the Commonwealth.

Amending the manual allows Virginia to keep its regulations up-to-date with new chemicals and how they may be used or transported. Without these amendments, natural gas-powered vehicles and carriers of low-pressure liquid oxygen not in conformance with the amendments will be unable to use the tunnels.

STATEMENT

Substance: The substance of the Hazardous Materials Transportation Manual deals with the rules and regulations (including operating requirements) under which hazardous materials can be transported through bridges and tunnels. The proposed amendments change the form and type of hazardous materials which can be transported through the facilities.

Issues: The issues raised by the manual pertain to the kinds of hazardous substances which can be transported, and the forms in which they may be transported. These amendments pertain to pilot programs using fuels other than gasoline or diesel fuel to power vehicles, as well as concerns by commercial carriers over the restrictiveness of current regulations.

Basis: The basis of the manual is to regulate the transportation of various hazardous materials across the bridges, tunnels, and ferries of the Commonwealth, as provided for by § 33.1-12(3) and 33.1-49 of the Code of Virginia. The amendments change the regulations to permit vehicles using natural gas or similar gases as motor fuels to use the tunnel and bridges, and also change the restrictions under which low-pressure liquid oxygen may be transported on these facilities. The manual must conform to regulations of the Commonwealth of Virginia and Federal Department of Transportation regulations.

Purpose: The purpose of the manual is to regulate the transportation of hazardous materials on bridges and tunnels. The proposed amendments amend the rules and regulations, including operating requirements, to allow vehicles using natural gas or other similar gas as a fuel to use the bridges and tunnels, and to change the restrictions under which low-pressure liquid oxygen may be transported across these facilities.

Impact: The impact of the manual is limited to shippers and transporters who must comply with the federal regulations (Title 49), and who use the bridge-tunnel facilities in daily operations. There will be no cost to the regulated parties or the department to implement the proposed amendments, and no negative effects will fall on small businesses or organizations operating under Title 49. If the amendments are not approved, neither vehicles using natural gas or other such fuels, nor low-pressure liquid oxygen transported as proposed will be allowed to use the bridge-tunnel. This prohibition will adversely affect the desirability of alternative-fuel programs, and will restrict commercial transportation of liquid oxygen.

Statutory Authority: §§ 33.1-12(3) and 33.1-49 of the Code of Virginia.

Written comments may be submitted until August 17, 1992, to Mr. J.L. Butner, Traffic Engineering Division, Virginia Department of Transportation, 1401 E. Broad Street, Richmond, VA 23219.

Contact: C.A. Abernathy, Transportation Engineer, Traffic Engineering Division, Virginia Department of Transportation, Room 206, Highway Annex, 1401 E. Broad Street, Richmond, VA 23219, telephone (804) 786-2889.

TREASURY BOARD

† **June 9, 1992 - 9:30 a.m.** – Open Meeting
James Monroe Building, 101 North 14th Street, 3rd floor, Treasury Board Conference Room, Richmond, Virginia. ♿

A special meeting.

† **June 17, 1992 - 9 a.m.** – Open Meeting
James Monroe Building, 101 North 14th Street, 3rd floor, Treasury Board Conference Room, Richmond, Virginia. ♿

A regular meeting.

Contact: Belinda Blanchard, Assistant Investment Officer, Department of the Treasury, P.O. Box 6-H, Richmond, VA 23215, telephone (804) 225-2142.

BOARD OF VETERINARY MEDICINE

† **June 3, 1992 - 8:30 a.m.** – Open Meeting
Holiday Inn-Patriot, 3032 Richmond, Road, Williamsburg, Virginia. ♿ (Interpreter for deaf provided upon request)

A meeting to (i) review general board business; (ii) hold formal hearings; and (iii) conduct regulatory review.

Contact: Terri H. Behr, Administrative Assistant, 1601 Rolling Hills Drive, Richmond, VA 23229, telephone (804) 662-9915.

VIRGINIA RESOURCES AUTHORITY

† **June 9, 1992 - 9 a.m.** – Open Meeting
Virginia Beach Ramada Oceanside Tower Resort and Conference Center, 57th and Oceanside, Virginia Beach, Virginia.

The board will meet to (i) approve minutes of its April 14, 1992, meeting; (ii) review the authority's operations for the prior months; and (iii) consider other matters and take other actions as it may deem appropriate. The planned agenda of the meeting will be available at the offices of the authority one week prior to the date of the meeting.

Public comments will be received at the beginning of the meeting.

Contact: Mr. Shockley D. Gardner, Jr., 909 East Main Street, Suite 707, Mutual Building, Richmond, VA 23219, telephone (804) 644-3100 or FAX number (804) 644-3109.

DEPARTMENT FOR THE VISUALLY HANDICAPPED

Advisory Committee on Services

July 25, 1992 - 11 a.m. – Open Meeting
Administrative Headquarters, 397 Azalea Avenue, Richmond, Virginia. ♿ (interpreter for deaf provided upon request)

A meeting to advise the Virginia Board for the Visually Handicapped on matters related to services for blind and visually impaired citizens of the Commonwealth.

Contact: Barbara G. Tyson, Executive Secretary, 397 Azalea Avenue, Richmond, VA 23227, telephone (804) 371-3140/TDD ☎ or toll-free 1-800-622-2155.

BOARD FOR WASTE MANAGEMENT FACILITY OPERATORS

June 12, 1992 - 8:30 a.m. – Open Meeting
Virginia Department of Commerce, 3600 West Broad Street, Conference Room 1, Richmond, Virginia. ♿

A general board meeting.

Contact: Nelle P. Hotchkiss, Assistant Director, Virginia Department of Commerce, 3600 W. Broad Street, Richmond, Virginia 23234, telephone (804) 367-8595 or (804) 367-9753/TDD ☎

DEPARTMENT OF WASTE MANAGEMENT (VIRGINIA WASTE MANAGEMENT BOARD)

June 9, 1992 - 9 a.m. – Open Meeting
General Assembly Building, House Room C, 9th and Broad Streets, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

A meeting on the proposed amendments to the Solid Waste Management Regulations, VR 672-20-10.

June 9, 1992 - 10:30 a.m. – Open Meeting
General Assembly Building, House Room C, 9th and Broad Streets, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

A meeting on the proposed amendments to the Hazardous Waste Management Regulations, VR 672-10-1.

Contact: Michael P. Murphy, Environmental Programs Manager, Virginia Department of Waste Management, 11th Floor, Monroe Building, 101 N. 14th Street, Richmond, Virginia 23219, telephone (804) 371-0044 or (804) 371-8737/TDD ☎

June 11, 1992 - 7:30 p.m. – Open Meeting
West Point Town Hall, 6th and Main Streets, West Point, Virginia.

Pursuant to the requirements of Part VII, Permitting of Solid Waste Management Facilities, of the Virginia Solid Waste Management Regulations, the draft Solid Waste Disposal Facility Permit for the development of an industrial landfill proposed by Chesapeake Paper Products Company is available for public review and comment. The permit allows the proposed facility to accept only authorized, nonhazardous wastes which result from the operations of Chesapeake Paper Products Company. The proposal incorporates design elements for a synthetic cap which is not provided for in the regulations. Chesapeake Paper Products Company petitioned for these features pursuant to the requirements of Part IX of the regulations (Rulemaking Petitions and Procedures), and the Department of Waste Management has granted tentative approval.

Contact: Khoi T. Nguyen, Environmental Engineer Senior, Virginia Department of Waste Management, 11th Floor, Monroe Building, 101 N. 14th Street, Richmond, Virginia 23219, telephone (804) 371-0658 or (804) 371-8737/TDD ☎

† **June 17, 1992 - 8:30 a.m.** – Open Meeting
The Omni Hotel, Lobby, Virginia Beach, Virginia.

The board will tour Mount Trashmore Visitors Center, 300 Edwin Drive, Virginia Beach; Virginia Beach Landfill, 1989 Jake Sears Road, Virginia Beach; Southeastern Public Service Authority Landfill, 1 Bob Foeller Drive, Suffolk, Virginia; RDF Plant, 4 Victory Boulevard, Portsmouth, Virginia; and Norfolk Transfer Station, 3136 Woodland Avenue, Norfolk, Virginia. This is only a tour. No decisions will be made and no business will be discussed.

Contact: Loraine Williams, Executive Secretary, 101 N. 14th Street, Monroe Building, 11th Floor, Richmond, Virginia 23219, telephone (804) 225-2667 or (804) 225-3753/TDD ☎

† **June 18, 1992 - 10 a.m.** – Open Meeting

The Virginia Beach Council Chambers, 2nd Floor City Hall, Municipal Center, Courthouse Drive and N. Landing Road, Virginia Beach, Virginia. ♿

A general business meeting to seek authorization from the Virginia Waste Management Board to hold public hearings on revisions to the Solid Waste Management Regulations (VR 672-20-10). Staff will seek authorization from the board to hold public hearings on revisions to the Hazardous Waste Management Regulations (VR 672-10-1). Staff will seek authorization from the board to hold public hearings on the Public Participation Guidelines Regulation (VR 672-01-1). (They were published February, 1985 - VR 352-01-1). An update will be given on enforcement procedures and sites.

Contact: Loraine Williams, Executive Secretary, 101 N. 14th Street, Monroe Building, 11th Floor, Richmond, Virginia 23219, telephone (804) 225-2667 or (804) 225-3753/TDD ☎

STATE WATER CONTROL BOARD

† **June 17, 1992 - 7 p.m.** – Public Hearing
Town Hall, 131 Center Street, Narrows, Virginia. ♿

A public hearing to receive comments on the issuance or denial of Virginia Pollution Abatement (VPA) Permit No. VAP02061 for Norfolk and Western Railway Company Coal Dust Suppression Facility, 110 Franklin Road, S.E., Roanoke, Virginia 24042-0013. The proposed facility will be located on the banks of the New River, adjacent to Route 460 East of Narrows, just downstream of the Hoechst Celanese "Celco" Plant and will spray well water on coal carried by railcars in order to prevent or minimize the release of coal dust from the cars. There will be no discharge allowed by the permit.

Contact: Lori F. Jackson, Hearings Reporter, Office of Policy Analysis, State Water Control Board, P.O. Box 11143, 4900 Cox Road, Glen Allen, Virginia 23063, telephone (804) 527-5163.

† **June 22, 1992 - 10 a.m.** – Open Meeting
4900 Cox Road, Board Room (Room 1000), Glen Allen, Virginia. ♿

A regular quarterly meeting.

Contact: Doneva A. Dalton, Hearings Reporter, State Water Control Board, P.O. Box 11143, Richmond, Virginia 23230, telephone (804) 527-5162.

BOARD FOR WATERWORKS AND WASTEWATER WORKS OPERATORS

June 25, 1992 - 10 a.m. – Public Hearing
Virginia Department of Commerce, 3600 West Broad Street, Richmond, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board for Waterworks and Wastewater Works Operators intends to amend regulations entitled: **VR 675-01-02. Board for Waterworks and Wastewater Works Operators Regulations.** The proposed regulation will adjust the fee structure of the board and bring the fee structure of the board in line with costs to cover the preparation of the examinations by an outside examination vendor.

Statutory Authority: §§ 54.1-113, 54.1-201, 54.1-202, and 54.1-2301 B of the Code of Virginia.

Written comments may be submitted until June 22, 1992.

Contact: Mr. Geralde W. Morgan, Administrator, Department of Commerce, 3600 W. Broad Street, Richmond, Virginia 23230-4917, telephone (804) 367-8534.

LEGISLATIVE

BLUE RIDGE ECONOMIC DEVELOPMENT COMMISSION

† **June 12, 1992 - 10 a.m.** – Open Meeting
Virginia Western Community College, Auditorium, 3095 Colonial Avenue, S.W., Roanoke, Virginia.

First meeting of the interim for this continued commission on economy in Blue Ridge area. Full commission meeting to be followed by task force meetings at 1 p.m. (HJR 107)

Contact: Edie T. Conley, Division of Legislative Services, 910 Capitol Street, Richmond, VA 23219, telephone (804) 786-3591.

VIRGINIA CODE COMMISSION

June 3, 1992 - 9:30 a.m. – Open Meeting
June 24, 1992 - 9:30 a.m. – Open Meeting
General Assembly Building, 6th Floor Conference Room, Richmond, Virginia.

A general business meeting.

July 15, 1992 - 9:30 a.m. – Open Meeting
General Assembly Building, 6th Floor Conference Room, Richmond, Virginia.

A general business meeting, including a review of the draft revision of Title 24.1 (Election Laws).

Contact: Joan W. Smith, Virginia Code Commission, 910

Capitol Street, Richmond, VA 23219, telephone (804) 786-3591.

† **June 22, 1992 - 10 a.m.** – Open Meeting
General Assembly Building, 6th Floor Conference Room, Richmond, Virginia.

Revision of the alcoholic beverage laws (Title 4). (SJR 13)

Contact: Maria Everett, Division of Legislative Services, 910 Capitol Street, Richmond, VA 23219, telephone (804) 786-3591.

COMMISSION ON POPULATION GROWTH AND DEVELOPMENT

June 18, 1992 - 9:30 a.m. – Open Meeting
June 19, 1992 - 9:30 a.m. – Open Meeting
Roslyn Conference Center, Richmond, Virginia.

A meeting to discuss developing growth strategies at the local and regional levels.

Contact: Katherine L. Imhoff, Executive Director, General Assembly Building, Suite 519B, 910 Capitol Street, Richmond, VA 23219, telephone (804) 371-4949.

JOINT SUBCOMMITTEE STUDYING WORKER'S COMPENSATION INSURANCE

† **June 11, 1992 - 10 a.m.** – Open Meeting
General Assembly Building, Senate Room B, First Floor, Richmond, Virginia.
The subcommittee will meet for purpose of reviewing carryover legislation.

Contact: Mark C. Pratt, Division of Legislative Services, 910 Capitol Street, Richmond, VA 23219, telephone (804) 786-3591.

CHRONOLOGICAL LIST

OPEN MEETINGS

June 1
Outdoors Foundation, Virginia

June 2
Agriculture and Consumer Services, Department of
- Virginia Marine Products Board

† Child Day Care and Early Childhood Programs, Council on
Hopewell Industrial Safety Council

June 3
Chesapeake Bay Local Assistance Board
- Southern Area Review Committee

Code Commission, Virginia
† Veterinary Medicine, Board of

June 4
Chesapeake Bay Local Assistance Board
Emergency Planning Committee, Local - Chesterfield County
Geology, Board for
† Middle Virginia Board of Directors and the Middle Virginia Community Corrections Resources Board
Nursing Home Administrators, Board of

June 5
† Conservation and Recreation, Department of
- Recreation in the Juvenile Justice System Advisory Board

Geology, Board for
† Rehabilitative Services, Department of

June 6
† Conservation and Recreation, Department of
- Virginia Cave Board

June 8
Alcoholic Beverage Control Board
† Barbers, Board for
Chesapeake Bay Local Assistance Board
- Central Area Review Committee

† Medical Assistance Services, Board of
† Nursing, Board of
- Special Conference Committee

† Real Estate Board
† Rehabilitative Services, Department of

June 9
† Health, Board of
† Higher Education for Virginia, State Council of
† Labor and Industry, Department of
- Safety and Health Codes Board

† Nursing, Board of
- Special Conference Committee

† Real Estate Board
† Rehabilitative Services, Department of
† Treasury Board
† Virginia Resources Authority
Waste Management, Department of

June 10
Aging, Department for the
- Governor's Advisory Board on Aging

† Agriculture and Consumer Services, Department of
- Virginia Sweet Potato Board

Chesapeake Bay Local Assistance Board
- Northern Area Review Committee
- Regulatory Review Committee and Program Study Group

Emergency Planning Committee, Local - City of Alexandria
† Health, Board of
† Health Professions, Department of

- Compliance and Discipline Committee
- Subcommittee on Board Member Complaint Adjudication

† Innovative Technology, Center for
- Review Committee

† Pharmacy, Board of

June 11

Aging, Department for the
- Governor's Advisory Board on Aging

† Chesapeake Bay Local Assistance Board
- Northern Area Review Committee

† Child Day-Care Council
† Criminal Justice Services Board
- Committee on Criminal Justice Information Systems

† Pharmacy, Board of
† Public Telecommunications Board, Virginia
† Rehabilitative Services, Department of
Waste Management, Department of
† Workers Compensation Insurance, Joint Subcommittee Studying

June 12

† Blue Ridge Economic Development Commission
† Mental Health, Mental Retardation and Substance Abuse Services, Department of
- State Human Rights Committee

Waste Management Facility Operators, Board for

June 15

Code Commission, Virginia
Emergency Planning Committee, Local - Prince William County, Manassas City, and Manassas Park City
Professional Counselors, Board of

June 16

† Housing Development Authority, Virginia
Labor and Industry, Department of
- Apprenticeship Council

Professional Counselors, Board of
† Real Estate Appraiser Board

June 17

Chesapeake Bay Local Assistance Board
- Regulatory Review Committee and Program Study Group

† Conservation and Recreation, Department of
- Board of Conservation and Recreation

Corrections, Board of
† Historic Resources, Department of
- State Review Board
- Historic Resources Board

† Local Debt, State Council on
Professional Counselors, Board of
Social Services, State Board of
† Transportation Board, Commonwealth
† Treasury Board
† Waste Management Board, Virginia

June 18

† Conservation and Recreation, Department of
- Virginia Soil and Conservation Board

† Fire Services Board, Virginia
- Fire/EMS Training and Education Committee
- Fire Prevention and Control Committee
- Legislative/Liaison Committee

Historic Resources, Department of
† Medical Assistance Services, Department of
- Drug Utilization Review Board

Population Growth and Development, Commission on
Mapping, Surveying and Land Information Systems, Advisory Commission on
Professional Counselors, Board of
Social Services, State Board of
† Transportation Board, Commonwealth
† Waste Management Board, Virginia

June 19

† Conservation and Recreation, Department of
- Falls of the James Scenic River Advisory Board

† Fire Services Board, Virginia
Interdepartmental Regulation of Residential Facilities for Children
- Coordinating Committee

Population Growth and Development, Commission on
Professional Counselors, Board of

June 20

Dentistry, Board of
Medicine, Board of
- Credentials Committee

June 22

Alcoholic Beverage Control Board
Chesapeake Bay Local Assistance Board
- Central Area Review Committee

† Code Commission, Virginia
† Cosmetology, Board for
† Water Control Board, State

June 23

† Chesapeake Bay Local Assistance Board
- Northern Area Review Committee

† Cosmetology, Board for
Health Services Cost Review Council, Virginia
Library Board
Marine Resources Commission
Polygraph Examiners Advisory Board

June 24

Chesapeake Bay Local Assistance Board
- Northern Area Review Committee
- Regulatory Review Committee and Program Study Group

Code Commission, Virginia
† Contractors, Board for
- Complaints Committee

Education, Board of
† Medicine, Board of
† Mental Health, Mental Retardation and Substance Abuse Board, State

June 25
Compensation Board

June 26
Medicine, Board of
- Advisory Committee on Physician's Assistants

June 30
Aging, Department for the
- Long-Term Care Ombudsman Advisory Council

July 7
Agriculture and Consumer Services, Department of
- Virginia Winegrowers Advisory Board
Hopewell Industrial Safety Council

July 9
Agriculture and Consumer Services, Department of
- Virginia Cattle Industry Board

July 10
Medicine, Board of
- Advisory Board on Physical Therapy

July 15
† Code Commission, Virginia
Social Services, State Board of

July 16
Social Services, State Board of

July 25
Visually Handicapped, Department for the
- Advisory Committee on Services

July 28
Marine Resources Commission

July 30
† Education, Board of

PUBLIC HEARINGS

June 11
Transportation, Department of

June 17
† Water Control Board, State

June 18
Transportation, Department of

June 19
Social Services, Department of

June 25
Waterworks and Wastewater Works Operators, Board for

July 1
Air Pollution Control Board, State

July 4
Medicine, Board of

July 8
† Air Pollution Control Board, State

July 15
† Air Pollution Control Board, State

July 16
Labor and Industry, Department of
- Apprenticeship Council

July 22
† Air Pollution Control Board, State

July 27
Lottery Department, State

August 10
† Transportation, Department of