VIRGINIA REGISTER OF REGULATIONS

VOL. 27 ISS. 19 | PUBLISHED EVERY OTHER WEEK BY THE VIRGINIA CODE COMMISSION | MAY 23, 2011

TABLE OF CONTENTS

THE VIRGINIA REGISTER OF REGULATIONS (USPS 001-831) is published biweekly by Matthew Bender & Company, Inc., 1275 Broadway, Albany, NY 12204-2694 for $197.00 per year. Periodical postage is paid in Albany, NY and at additional mailing offices. POSTMASTER: Send address changes to The Virginia Register of Regulations, 136 Carlin Road, Conklin, NY 13748-1531.

THE VIRGINIA REGISTER INFORMATION PAGE

THE VIRGINIA REGISTER OF REGULATIONS is an official state publication issued every other week throughout the year. Indexes are published quarterly, and are cumulative for the year. The *Virginia Register* has several functions. The new and amended sections of regulations, both as proposed and as finally adopted, are required by law to be published in the *Virginia Register*. In addition, the *Virginia Register* is a source of other information about state government, including petitions for rulemaking, emergency regulations, executive orders issued by the Governor, and notices of public hearings on regulations.

ADOPTION, AMENDMENT, AND REPEAL OF REGULATIONS

An agency wishing to adopt, amend, or repeal regulations must first publish in the *Virginia Register* a notice of intended regulatory action; a basis, purpose, substance and issues statement; an economic impact analysis prepared by the Department of Planning and Budget; the agency's response to the economic impact analysis; a summary; a notice giving the public an opportunity to comment on the proposal; and the text of the proposed regulation.

Following publication of the proposal in the Virginia Register, the promulgating agency receives public comments for a minimum of 60 days. The Governor reviews the proposed regulation to determine if it is necessary to protect the public health, safety and welfare, and if it is clearly written and easily understandable. If the Governor chooses to comment on the proposed regulation, his comments must be transmitted to the agency and the Registrar no later than 15 days following the completion of the 60-day public comment period. The Governor's comments, if any, will be published in the *Virginia Register*. Not less than 15 days following the completion of the 60-day public comment period, the agency may adopt the proposed regulation.

The Joint Commission on Administrative Rules (JCAR) or the appropriate standing committee of each house of the General Assembly may meet during the promulgation or final adoption process and file an objection with the Registrar and the promulgating agency. The objection will be published in the *Virginia Register*. Within 21 days after receipt by the agency of a legislative objection, the agency shall file a response with the Registrar, the objecting legislative body, and the Governor.

When final action is taken, the agency again publishes the text of the regulation as adopted, highlighting all changes made to the proposed regulation and explaining any substantial changes made since publication of the proposal. A 30-day final adoption period begins upon final publication in the *Virginia Register*.

The Governor may review the final regulation during this time and, if he objects, forward his objection to the Registrar and the agency. In addition to or in lieu of filing a formal objection, the Governor may suspend the effective date of a portion or all of a regulation until the end of the next regular General Assembly session by issuing a directive signed by a majority of the members of the appropriate legislative body and the Governor. The Governor's objection or suspension of the regulation, or both, will be published in the *Virginia Register*. If the Governor finds that changes made to the proposed regulation have substantial impact, he may require the agency to provide an additional 30-day public comment period on the changes. Notice of the additional public comment period required by the Governor will be published in the *Virginia Register*.

The agency shall suspend the regulatory process for 30 days when it receives requests from 25 or more individuals to solicit additional public comment, unless the agency determines that the changes have minor or inconsequential impact.

A regulation becomes effective at the conclusion of the 30-day final adoption period, or at any other later date specified by the promulgating agency, unless (i) a legislative objection has been filed, in which event the regulation, unless withdrawn, becomes effective on the date specified, which shall be after the expiration of the 21-day objection period; (ii) the Governor exercises his authority to require the agency to provide for additional public comment, in which event the regulation, unless withdrawn, becomes effective on the date specified, which shall be after the expiration of the period for which the Governor has provided for additional public comment; (iii) the Governor and the General Assembly exercise their authority to suspend the effective date of a regulation until the end of the next regular legislative session; or (iv) the agency suspends the regulatory process, in which event the regulation, unless withdrawn, becomes effective on the date specified, which shall be after the expiration of the 30-day public comment period and no earlier than 15 days from publication of the readopted action.

A regulatory action may be withdrawn by the promulgating agency at any time before the regulation becomes final.

FAST-TRACK RULEMAKING PROCESS

Section 2.2-4012.1 of the Code of Virginia provides an exemption from certain provisions of the Administrative Process Act for agency regulations deemed by the Governor to be noncontroversial. To use this process, Governor's concurrence is required and advance notice must be provided to certain legislative committees. Fast-track regulations will become effective on the date noted in the regulatory action if no objections to using the process are filed in accordance with § 2.2-4012.1.

EMERGENCY REGULATIONS

Pursuant to § 2.2-4011 of the Code of Virginia, an agency, upon consultation with the Attorney General, and at the discretion of the Governor, may adopt emergency regulations that are necessitated by an emergency situation. An agency may also adopt an emergency regulation when Virginia statutory law or the appropriation act or federal law or federal regulation requires that a regulation be effective in 280 days or less from its enactment. The emergency regulation becomes operative upon its adoption and filing with the Registrar of Regulations, unless a later date is specified. Emergency regulations are limited to no more than 12 months in duration; however, may be extended for six months under certain circumstances as provided for in § 2.2-4011 D. Emergency regulations are published as soon as possible in the *Register*.

During the time the emergency status is in effect, the agency may proceed with the adoption of permanent regulations through the usual procedures. To begin promulgating the replacement regulation, the agency must (i) file the Notice of Intended Regulatory Action with the Registrar within 60 days of the effective date of the emergency regulation and (ii) file the proposed regulation with the Registrar within 180 days of the effective date of the emergency regulation. If the agency chooses not to adopt the regulations, the emergency status ends when the prescribed time limit expires.

STATEMENT

The foregoing constitutes a generalized statement of the procedures to be followed. For specific statutory language, it is suggested that Article 2 (§ 2.2-4006 et seq.) of Chapter 40 of Title 2.2 of the Code of Virginia be examined carefully.

CITATION TO THE *VIRGINIA REGISTER*

The *Virginia Register* is cited by volume, issue, page number, and date. **26:20 VA.R. 2510-2515 June 7, 2010,** refers to Volume 26, Issue 20, pages 2510 through 2515 of the *Virginia Register* issued on June 7, 2010.

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

PUBLICATION SCHEDULE AND DEADLINES

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

May 2011 through June 2012

Volume: Issue	Material Submitted By Noon*	Will Be Published On
27:19	May 4, 2011	May 23, 2011
27:20	May 18, 2011	June 6, 2011
27:21	June 1, 2011	June 20, 2011
27:22	June 15, 2011	July 4, 2011
27:23	June 29, 2011	July 18, 2011
27:24	July 13, 2011	August 1, 2011
27:25	July 27, 2011	August 15, 2011
27:26	August 10, 2011	August 29, 2011
28:1	August 24, 2011	September 12, 2011
28:2	September 7, 2011	September 26, 2011
28:3	September 21, 2011	October 10, 2011
28:4	October 5, 2011	October 24, 2011
28:5	October 19, 2011	November 7, 2011
28:6	November 2, 2011	November 21, 2011
28:7	November 15, 2011 **(Tuesday)**	December 5, 2011
28:8	November 30, 2011	December 19, 2011
28:9	December 13, 2011 **(Tuesday)**	January 2, 2012
28:10	December 27, 2011 **(Tuesday)**	January 16, 2012
28:11	January 11, 2012	January 30, 2012
28:12	January 25, 2012	February 13, 2012
28:13	February 8, 2012	February 27, 2012
28:14	February 22, 2012	March 12, 2012
28:15	March 7, 2012	March 26, 2012
28:16	March 21, 2012	April 9, 2012
28:17	April 4, 2012	April 23, 2012
28:18	April 18, 2012	May 7, 2012
28:19	May 2, 2012	May 21, 2012
28:20	May 16, 2012	June 4, 2012

*Filing deadlines are Wednesdays unless otherwise specified.

PETITIONS FOR RULEMAKING

TITLE 12. HEALTH

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

Initial Agency Notice

Title of Regulation: **12VAC35-115. Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers of Mental Health, Mental Retardation and Substance Abuse Services.**

Statutory Authority: § 37.2-400 of the Code of Virginia.

Name of Petitioner: Steven Shoon.

Nature of Petitioner's Request: Establish a new provision in the Human Rights regulations that prohibits Virginia State Training Centers from requiring chosen representatives to have Training Center authorization prior to have access to the residents service records for the residents they represent pursuant to the human rights complaint resolution process.

Agency's Plan for Disposition of Request: The board will consider this petition at the next scheduled meeting after the public has had sufficient time to comment.

Public Comment Deadline: June 12, 2011.

Agency Contact: Linda B. Grasewicz, Regulatory Coordinator, Department of Behavioral Health and Developmental Services, 1220 Bank Street, Richmond, VA 23218-1797, telephone (804) 786-0040, or email linda.grasewicz@dbhds.virginia.gov.

VA.R. Doc. No. R11-33; Filed May 2, 2011, 3:10 p.m.

Initial Agency Notice

Title of Regulation: **12VAC35-115. Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers of Mental Health, Mental Retardation and Substance Abuse Services.**

Statutory Authority: § 37.2-400 of the Code of Virginia.

Name of Petitioner: Steven Shoon.

Nature of Petitioner's Request: Establish a new provision in the Human Rights regulations that requires Virginia State Training Centers to petition Virginia Judicial Districts to assign the population they service legal guardians.

Agency's Plan for Disposition of Request: The board will consider this petition at the next scheduled meeting after the public has had sufficient time to comment.

Public Comment Deadline: June 12, 2011.

Agency Contact: Linda B. Grasewicz, Regulatory Coordinator, Department of Behavioral Health and Developmental Services, 1220 Bank Street, Richmond, VA 23218-1797, telephone (804) 786-0040, or email linda.grasewicz@dbhds.virginia.gov.

VA.R. Doc. No. R11-34; Filed May 2, 2011, 3:00 p.m.

Initial Agency Notice

Title of Regulation: **12VAC35-115. Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers of Mental Health, Mental Retardation and Substance Abuse Services.**

Statutory Authority: § 37.2-400 of the Code of Virginia.

Name of Petitioner: Steven Shoon.

Nature of Petitioner's Request: Amend 12VAC35-115 to require CSBs and Virginia State Training Centers to physically post FOIA information prescribed under § 2.2-3704.1 of the Code of Virginia.

Agency's Plan for Disposition of Request: The board will consider this petition at the next scheduled meeting after the public has had sufficient time to comment.

Public Comment Deadline: June 12, 2011.

Agency Contact: Linda B. Grasewicz, Regulatory Coordinator, Department of Behavioral Health and Developmental Services, 1220 Bank Street, Richmond, VA 23218-1797, telephone (804) 786-0040, or email linda.grasewicz@dbhds.virginia.gov.

VA.R. Doc. No. R11-35; Filed May 2, 2011, 2:46 p.m.

Initial Agency Notice

Title of Regulation: **12VAC35-115. Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers of Mental Health, Mental Retardation and Substance Abuse Services.**

Statutory Authority: § 37.2-400 of the Code of Virginia.

Name of Petitioner: Steven Shoon.

Nature of Petitioner's Request: Amend 12VAC35-115-10 to separate the legal aspects, administrative aspects, and clinical aspects of the Department of Behavioral Health and Developmental Services duties.

Agency's Plan for Disposition of Request: The board will consider this petition at the next scheduled meeting after the public has had sufficient time to comment.

Public Comment Deadline: June 12, 2011.

Agency Contact: Linda B. Grasewicz, Regulatory Coordinator, Department of Behavioral Health and Developmental Services, 1220 Bank Street, Richmond, VA 23218-1797, telephone (804) 786-0040, or email linda.grasewicz@dbhds.virginia.gov.

VA.R. Doc. No. R11-36; Filed May 2, 2011, 3:01 p.m.

Initial Agency Notice

Title of Regulation: **12VAC35-115. Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers of Mental Health, Mental Retardation and Substance Abuse Services.**

Statutory Authority: § 37.2-400 of the Code of Virginia.

Name of Petitioner: Steven Shoon.

Nature of Petitioner's Request: Amend 12VAC35-115-30 definition of "providers" to include the Commissioner, State Human Rights Director (SHRD), Human Rights Advocate and governing bodies of licensed providers.

Agency's Plan for Disposition of Request: The board will consider this petition at the next scheduled meeting after the public has had sufficient time to comment.

Public Comment Deadline: June 12, 2011.

Agency Contact: Linda B. Grasewicz, Regulatory Coordinator, Department of Behavioral Health and Developmental Services, 1220 Bank Street, Richmond, VA 23218-1797, telephone (804) 786-0040, or email linda.grasewicz@dbhds.virginia.gov.

VA.R. Doc. No. R11-37; Filed May 2, 2011, 2:39 p.m.

Initial Agency Notice

Title of Regulation: **12VAC35-115. Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers of Mental Health, Mental Retardation and Substance Abuse Services.**

Statutory Authority: § 37.2-400 of the Code of Virginia.

Name of Petitioner: Steven Shoon.

Nature of Petitioner's Request: Amend 12VAC35-115-80 to require providers notify an individual receiving services that a person, other than a healthcare provider, attempted to contact the individual when a person has attempted to contact them.

Agency's Plan for Disposition of Request: The board will consider this petition at the next scheduled meeting after the public has had sufficient time to comment.

Public Comment Deadline: June 12, 2011.

Agency Contact: Linda B. Grasewicz, Regulatory Coordinator, Department of Behavioral Health and Developmental Services, 1220 Bank Street, Richmond, VA 23218-1797, telephone (804) 786-0040, or email linda.grasewicz@dbhds.virginia.gov.

VA.R. Doc. No. R11-38; Filed May 2, 2011, 2:53 p.m.

Initial Agency Notice

Title of Regulation: **12VAC35-115. Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers of Mental Health, Mental Retardation and Substance Abuse Services.**

Statutory Authority: § 37.2-400 of the Code of Virginia.

Name of Petitioner: Steven Shoon.

Nature of Petitioner's Request: Amend 12VAC35-115-180 and 12VAC35-115-210 to require hearing boards seek advisory opinions upon the request of the petitioner.

Agency's Plan for Disposition of Request: The board will consider this petition at the next scheduled meeting after the public has had sufficient time to comment.

Public Comment Deadline: June 12, 2011.

Agency Contact: Linda B. Grasewicz, Regulatory Coordinator, Department of Behavioral Health and Developmental Services, 1220 Bank Street, Richmond, VA 23218-1797, telephone (804) 786-0040, or email linda.grasewicz@dbhds.virginia.gov.

VA.R. Doc. No. R11-39; Filed May 2, 2011, 2:35 p.m.

Agency Decision

Title of Regulation: **12VAC35-115. Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers of Mental Health, Mental Retardation and Substance Abuse Services.**

Statutory Authority: § 37.2-400 of the Code of Virginia.

Name of Petitioner: Steven Shoon.

Nature of Petitioner's Request: Amend 12VAC35-115-30 definitions of "restriction" and "seclusion" to define a distinction between one another.

Agency Decision: Denied.

Statement of Reason for Decision: Given the context in which these definitions are used in the regulations, the current definitions are sufficient.

Agency Contact: Linda B. Grasewicz, Regulatory Coordinator, Department of Behavioral Health and Developmental Services, 1220 Bank Street, Richmond, VA 23218-1797, telephone (804) 786-0040, or email linda.grasewicz@dbhds.virginia.gov.

VA.R. Doc. No. R11-20; Filed May 2, 2011, 2:15 p.m.

Agency Decision

Title of Regulation: **None specified.**

Statutory Authority: N/A.

Name of Petitioner: Steven Shoon.

Nature of Petitioner's Request: Promulgate new regulations requiring the Commissioner to request the FOI Advisory Council assistance in developing a guidance document for bridging the applicable meeting requirements under §§ 2.2-3702, 2.2-3704.1, 2.2-3707, 2.2-3707.1, 2.2-3708, 2.2-3708.1, 2.2-3710, 2.2-3711, 2.2-3712, 2.2-4007, 2.2-4031, and 2.2-3704 and to define the term "roll call" as used under 2.2-3710.

Agency Decision: Denied.

Statement of Reason for Decision: The board's authority in § 37.2-203 of the Code of Virginia to adopt regulations does not permit the requested action.

Agency Contact: Linda B. Grasewicz, Regulatory Coordinator, Department of Behavioral Health and Developmental Services, 1220 Bank Street, Richmond, VA 23218-1797, telephone (804) 786-0040, or email linda.grasewicz@dbhds.virginia.gov.

VA.R. Doc. No. R11-21; Filed May 2, 2011, 2:18 p.m.

Agency Decision

Title of Regulation: **None specified.**

Statutory Authority: N/A.

Name of Petitioner: Steven Shoon.

Nature of Petitioner's Request: Establish new regulations requiring a FOI Advisory Council study on what groupings within DBHDS constitute public bodies; and what convenings do and do not constitute a meeting under § 2.2-3701.

Agency Decision: Denied.

Statement of Reason for Decision: The board's authority in § 37.2-203 of the Code of Virginia to adopt regulations does not permit the requested action.

Agency Contact: Linda B. Grasewicz, Regulatory Coordinator, Department of Behavioral Health and Developmental Services, 1220 Bank Street, Richmond, VA 23218-1797, telephone (804) 786-0040, or email linda.grasewicz@dbhds.virginia.gov.

VA.R. Doc. No. R11-22; Filed May 2, 2011, 2:19 p.m.

Agency Decision

Title of Regulation: **None specified.**

Statutory Authority: N/A.

Name of Petitioner: Steven Shoon.

Nature of Petitioner's Request: Establish new regulations that mandate mental health consumers receiving inpatient hospitalization, outpatient treatment, or both; have access to meetings of the State Board; State Human Rights Committee (SHRC); and all Local Human Rights Committees (LHRCs) via electronic video/tele-conference pursuant to §§ 2.2-3708 and 2.2-3708.1.

Agency Decision: Denied.

Statement of Reason for Decision: The board's authority in § 37.2-203 of the Code of Virginia to adopt regulations does not permit the requested action.

Agency Contact: Linda B. Grasewicz, Regulatory Coordinator, Department of Behavioral Health and Developmental Services, 1220 Bank Street, Richmond, VA 23218-1797, telephone (804) 786-0040, or email linda.grasewicz@dbhds.virginia.gov.

VA.R. Doc. No. R11-23; Filed May 2, 2011, 2:21 p.m.

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARD OF DENTISTRY

Initial Agency Notice

Title of Regulation: **18VAC60-20. Regulations Governing Dental Practice.**

Statutory Authority: § 54.1-2700 of the Code of Virginia.

Name of Petitioner: Ann Bruhn.

Nature of Petitioner's Request: To amend regulations to permit accredited dental hygiene schools to offer radiation safety course for unlicensed persons to be certified in radiation safety.

Agency's Plan for Disposition of Request: The board is requesting public comment on the petition to amend regulations relating to radiation safety certification. The board will consider the need for amendment at its meeting on June 3, 2011, and will respond to the petition following the close of the comment period.

Public Comment Deadline: June 22, 2011.

Agency Contact: Elaine J. Yeatts, Agency Regulatory Coordinator, Department of Health Professions, 9960

Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4468, or email elaine.yeatts@dhp.virginia.gov.

VA.R. Doc. No. R11-40; Filed May 3, 2011, 3:37 p.m.

BOARD OF MEDICINE

Initial Agency Notice

Title of Regulation: **18VAC85-20. Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry, and Chiropractic.**

Statutory Authority: § 54.1-2900 of the Code of Virginia.

Name of Petitioner: Dr. Wilhelm Zuelzer.

Nature of Petitioner's Request: To allow two years in an ACGME accredited residency or fellowship to meet the educational requirements for graduates or former students of institutions not approved by an accrediting agency approved by the board.

Agency's Plan for Disposition of Request: The board will seek comment on the petition from May 23, 2011, to June 22, 2011, and will consider the request at its meeting on June 23, 2011.

Public Comment Deadline: June 22, 2011.

Agency Contact: Elaine J. Yeatts, Agency Regulatory Coordinator, Department of Health Professions, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4468, or email elaine.yeatts@dhp.virginia.gov.

VA.R. Doc. No. R11-41; Filed May 4, 2011, 9:14 a.m.

TITLE 22. SOCIAL SERVICES

STATE BOARD OF SOCIAL SERVICES

Withdrawal of Notice of Intended Regulatory Action

Notice is hereby given that the State Board of Social Services has WITHDRAWN the Notice of Intended Regulatory Action for 22VAC40-601, Food Stamp Program, which was published in 27:3 VA.R. 383 October 11, 2010.

Agency Contact: Karin Clark, Regulatory Coordinator, Department of Social Services, 801 East Main Street, Richmond, VA 23219, telephone (804) 726-7017, TTY (800) 828-1120, or email karin.clark@dss.virginia.gov.

VA.R. Doc. No. R11-2565; Filed April 25, 2011, 1:25 p.m.

TITLE 4. CONSERVATION AND NATURAL RESOURCES

MARINE RESOURCES COMMISSION

REGISTRAR'S NOTICE: The following regulations filed by the Marine Resources Commission are exempt from the Administrative Process Act in accordance with § 2.2-4006 A 11 of the Code of Virginia; however, the commission is required to publish the full text of final regulations.

Final Regulation

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

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

Effective Date: April 30, 2011.

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

Summary:

The amendment changes the times that it is unlawful to offload Summer Flounder for commercial purposes to 9 p.m. through 7 a.m.

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

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

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

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

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

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

1. Possess aboard any vessel in Virginia waters any amount of Summer Flounder in excess of 20,000 pounds.

2. Land Summer Flounder in Virginia for commercial purposes more than twice during each consecutive 15-day period, with the first 15-day period beginning on the first Monday in March.

3. Land in Virginia more than 10,000 pounds of Summer Flounder during each consecutive 15-day period, with the first 15-day period beginning on the first Monday in March.

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

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

1. Possess aboard any vessel in Virginia waters any amount of Summer Flounder in excess of 15,000 pounds.

2. Land Summer Flounder in Virginia for commercial purposes more than twice during each consecutive 12-day period, with the first 12-day period beginning on the last Monday in November.

3. Land in Virginia more than a total of 7,500 pounds of Summer Flounder during each consecutive 12-day period, with the first 12-day period beginning on the last Monday in November.

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

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

E. Upon request by a marine police officer, the seafood buyer or processor shall offload and accurately determine the

total weight of all Summer Flounder aboard any vessel landing Summer Flounder in Virginia.

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

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

H. It shall be unlawful for a licensed seafood buyer or federally permitted seafood buyer to fail to contact the Marine Resources Commission Operation Station prior to a vessel offloading Summer Flounder harvested outside of Virginia. The buyer shall provide to the Marine Resources Commission the name of the vessel, its captain, an estimate of the amount in pounds of Summer Flounder on board that vessel, and the anticipated or approximate offloading time. Once offloading of any vessel is complete and the weight of the landed Summer Flounder has been determined, the buyer shall contact the Marine Resources Commission Operations Station and report the vessel name and corresponding weight of Summer Flounder landed. It shall be unlawful for any person to offload from a boat or vessel for commercial purposes any Summer Flounder during the period of ~~6 p.m.~~ 9 p.m. to 7 a.m.

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

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

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

VA.R. Doc. No. R11-2831; Filed April 29, 2011, 8:39 a.m.

Final Regulation

Title of Regulation: **4VAC20-752. Pertaining to Blue Crab Sanctuaries (amending 4VAC20-752-20, 4VAC20-752-30).**

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

Effective Date: April 30, 2011.

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

Summary:

The amendments (i) modify the boundary line of area 1 of the Virginia Blue Crab Sanctuary that extends offshore from Smith Point to the Great Wicomico River and (ii) change the start date of the sanctuary closure from May 1 to May 16.

4VAC20-752-20. Definitions.

"COLREGS Line" means the COLREGS Demarcation lines, as specified in Coastal Pilot, 35th and 36th editions by Lighthouse Press.

"Three Nautical Mile Limit Line" means the outer limit of the area extending three miles out to sea from the coast as depicted on NOAA nautical charts.

"Virginia Blue Crab Sanctuary" means two distinct sanctuary areas, Area 1 and Area 2, with Area 1 consisting of all tidal waters that are bounded by a line beginning at a point, near the western shore of Fisherman's Island, being on a line from the Cape Charles Lighthouse to the Thimble Shoal Light; thence southwesterly to Thimble Shoal Light; thence southwesterly to the offshore end of Ocean View Fishing Pier (formerly Harrison's Fishing Pier); thence north to Flashing Green Buoy "9" on the York River Entrance Channel; thence northeasterly to Wolf Trap Light; thence northwesterly to a point, northeast of Windmill Point, 37° 38' 23.13" N, 76° 15'

59.54" W; thence northerly to a point, ~~due~~ east of Great Wicomico Light at 37° 48' 15.72" N, 76° 14' 33.15" W; thence northeasterly to a point, 37° 49' 18.10" N, 76° 13' 06.00" W; thence ~~northerly~~ northeasterly to Smith Point Lighthouse, 37° 52' 47.55" N, 76° 11' 01.50" W; thence northwesterly to a point on the Virginia-Maryland state line, 37° 54' ~~04.00~~ 04.99" N, 76° 11' ~~49.15~~ 44.96" W; thence northeasterly following the Virginia-Maryland state line to a point ~~on the Virginia-Maryland state line~~ on that line, 37° 55' ~~44.82~~ 43.79" N, 76° 07' ~~13.41~~ 12.87" W; thence southeasterly to a point, southwest of Tangier Island, 37° 44' 59.85" N, 76° 01' 34.31" W; thence southeasterly to a point, southeast of Tangier Island, 37° 43' 41.05" N, 75° 57' 51.84" W; thence northeasterly to a point, south of Watts Island, 37° 45' 36.95" N, 75° 52' 53.87" W; thence southeasterly to a point, 37° 44' 56.15" N, 75° 51' 33.18" W; thence southwesterly to a point, west of Parkers Marsh, 37° 42' 41.49" N, 75° 55' 06.31" W; thence southwesterly to a point, west of Cape Charles Harbor, 37° 15' 37.23" N, 76° 04' 13.79" W; thence southeasterly to a point near the western shore of Fisherman's Island, on the line from Cape Charles Lighthouse to Thimble Shoal Light, said point being the point of beginning, and a continuation of Area 1, consisting of all tidal waters that are bounded by a line beginning at Cape Charles Lighthouse; thence southwesterly to Cape Henry Lighthouse; thence southeasterly to a point, 36° 54' 42.39" N, 75° 56' 44.23" W; thence northeasterly to a point, east of Cape Charles Lighthouse 37° 06' 45" N, 75° 52' 05" W; thence westerly to the Cape Charles Lighthouse, said point being the point of beginning and a second area, Area 2, beginning at a point, 37° 06' 45.00" N, 75° 52' 05.00" W; thence southwesterly to a point, 37° 03' 11.49" N, 75° 53' 27.02" W, said point being a point on the Three Nautical Mile Limit Line; thence southerly following the Three Nautical Mile Limit Line to a point on the Virginia – North Carolina state boundary, 36° 33' 02.59" N, 75° 48' 16.21" W; thence westerly to a point, along the Virginia – North Carolina state boundary to its intersection with the mean low water line, 36° 33' 01.34" N, 75° 52' 03.06" W; thence northerly, following the mean low water line to the Rudee Inlet weir; thence easterly along the weir to the stone breakwater; thence following the stone breakwater to its northernmost point; thence northerly to the mean low water line at the easternmost point of the stone jetty; thence northerly following the mean low water line to its intersection with the COLREG Line, 36° 55' 38.50" N, 76° 00' 20.32" W; thence southeasterly to a point, 36° 54' 42.39" N, 75° 56' 44.23" W, thence northeasterly to a point, 37° 06' 45.00" N, 75° 52' 05.00" W, said point being the point of beginning of this second area.

4VAC20-752-30. Harvest restrictions.

A. It shall be unlawful for any person to conduct commercial or recreational crabbing within Area 1 of the Virginia Blue Crab Sanctuary from May ~~1~~ 16 through September 15.

B. It shall be unlawful for any person to take, harvest or possess crabs for commercial purposes from Area 2 from May ~~1~~ 16 through September 15.

VA.R. Doc. No. R11-2832; Filed April 29, 2011, 9:22 a.m.

Final Regulation

Title of Regulation: **4VAC20-900. Pertaining to Horseshoe Crab (amending 4VAC20-900-25, 4VAC20-900-30, 4VAC20-900-35, 4VAC20-900-40; adding 4VAC20-900-36, 4VAC20-900-37, 4VAC20-900-38).**

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

Effective Date: May 1, 2011.

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

Summary:

The amendments reduce the 2011 harvest quota to 130,933 horseshoe crabs and enhance harvest control measures and quota allocations by (i) requiring that all horseshoe crab harvesters call in daily harvest amounts; (ii) reducing initial landing limits for both the restricted and unrestricted horseshoe crab endorsement licenses by 50%; (iii) adjusting the landing limit triggers from 50% to 80%; (iv) initiating a license and permit moratorium for new entrants; (v) establishing a control date of December 31, 2010, to serve as a basis for the future development of horseshoe crab regulations; and (vi) suballocating the annual quota by gear types.

4VAC20-900-25. Commercial fisheries management measures.

A. It shall be unlawful for any person to harvest horseshoe crabs from any shore or tidal waters of Virginia within 1,000 feet in any direction of the mean low water line from May 1 through June 7. The harvests of horseshoe crabs for biomedical use shall not be subject to this limitation.

B. From January 1 through June 7 of each year, it shall be unlawful for any person to land, in Virginia, any horseshoe crab harvested from federal waters.

C. Harvests for biomedical purposes shall require a special permit issued by the Commissioner of Marine Resources, and all crabs taken pursuant to such permit shall be returned to the same waters from which they were collected.

D. The commercial quota of horseshoe crab for ~~2010~~ 2011 shall be ~~137,168~~ 130,933 horseshoe crabs. Additional quantities of horseshoe crab may be transferred to Virginia by other jurisdictions in accordance with the provisions of Addendum I to the Atlantic States Marine Fisheries Commission Fishery Management Plan for Horseshoe Crab,

April 2000, provided that the combined total of the commercial quota and transfer from other jurisdictions shall not exceed 355,000 horseshoe crabs. It shall be unlawful for any person to harvest from Virginia waters, or to land in Virginia, any horseshoe crab for commercial purposes after any calendar-year commercial quota of horseshoe crab has been attained and announced as such.

E. During each calendar year no more than 40% of the commercial horseshoe crab quota and any and all transfers of quota from other jurisdictions shall be harvested from waters east of the COLREGS Line. It shall be unlawful for any person to harvest horseshoe crabs from waters east of the COLREGS Line, or to land horseshoe crabs, in Virginia, that are harvested east of the COLREGS Line, after 40% of Virginia's horseshoe crab quota and any and all transfers of quota have been attained for this designated area and announced as such.

F. It shall be unlawful for any person whose harvest of horseshoe crabs is from waters east of the COLREGS Line to possess aboard a vessel or to land in Virginia any quantity of horseshoe crabs that, in aggregate, is not comprised of at least a minimum ratio of two male horseshoe crabs to one female horseshoe crab. For the purposes of this regulation, no horseshoe crab shall be considered a male horseshoe crab unless it possesses at least one modified, hook-like appendage as its first pair of walking legs.

G. Limitations on the daily harvest and possession of horseshoe crabs for any vessel described below are as follows:

1. It shall be unlawful for any person who ~~meets the requirements of 4VAC20-900-30 D and~~ holds a valid unrestricted horseshoe crab endorsement license, as described in 4VAC20-900-30 D, to possess aboard any vessel or to land any number of horseshoe crabs in excess of ~~5,000~~ 2,500, except that when it is projected and announced that ~~50%~~ 80% of the commercial quota is taken, it shall be unlawful for any person who meets the requirements of 4VAC20-900-30 D and holds a valid horseshoe crab endorsement license to possess aboard any vessel in Virginia any number of horseshoe crabs in excess of ~~2,500~~ 1,250.

2. It shall be unlawful for any person who ~~meets the requirements of 4VAC20-900-30 E and~~ holds a valid restricted horseshoe crab endorsement license, as described in 4VAC20-900-30 E, to possess aboard any vessel or to land any number of horseshoe crabs in excess of ~~2,000~~ 1,000, except that when it is projected and announced that ~~50%~~ 80% of the commercial quota is taken, it shall be unlawful for any person who meets the requirements of 4VAC20-900-30 E and holds a valid horseshoe crab endorsement license to possess aboard any vessel in Virginia any number of horseshoe crabs in excess of ~~1,000~~ 500. The harvest of horseshoe crabs, described in this subdivision, shall be restricted to using only crab dredge.

3. It shall be unlawful for any registered commercial fisherman or seafood landing licensee who does not possess a valid horseshoe crab endorsement license to possess horseshoe crabs, without first obtaining a valid horseshoe crab bycatch permit from the Marine Resources Commission. It shall be unlawful for a horseshoe crab bycatch permittee to possess aboard any vessel more than 500 horseshoe crabs or for any vessel to land any number of horseshoe crabs in excess of 500~~,~~ per day except as described in subdivision 4 of this subsection. When it is projected and announced that ~~50%~~ 80% of the commercial quota is taken, it shall be unlawful for any person with a horseshoe crab bycatch permit to possess aboard any vessel more than 250 horseshoe crabs or for any vessel to land any number of horseshoe crabs in excess of 250 per day except as described in subdivision 4 of this subsection.

4. It shall be unlawful for any two horseshoe crab bycatch permittees fishing from the same boat or vessel to possess or land more than 1,000 horseshoe crabs per day. When it is projected and announced that 80% of the commercial quota is taken, it shall be unlawful for any two horseshoe crab bycatch permittees fishing from the same boat or vessel to possess or land more than 500 horseshoe crabs per day.

5. It shall be unlawful for any registered commercial fisherman or seafood landing licensee who does not possess a horseshoe crab endorsement license or a horseshoe crab bycatch permit to possess any horseshoe crabs.

H. It shall be unlawful for any fisherman issued a horseshoe crab endorsement license to offload any horseshoe crabs between the hours of 10 p.m. and 7 a.m.

I. When it is projected and announced that ~~20%~~ 32% of the commercial quota, as described in ~~4 VAC20-900-25D~~ subsection D of this section, has been taken from waters east of the COLREGS line, the limitations on the possession and landing of horseshoe crabs are as follows:

1. It shall be unlawful for any person who possesses a valid unrestricted horseshoe crab endorsement license to possess aboard any vessel in waters east of the COLREGS Line or to land more than ~~2,500~~ 1,250 horseshoe crabs per day.

2. It shall be unlawful for any person who possesses a valid restricted horseshoe crab endorsement license to possess aboard any vessel in waters east of the COLREGS Line or to land more than ~~1,000~~ 500 horseshoe crabs per day.

3. It shall be unlawful for any person who possesses a valid horseshoe crab bycatch permit to possess aboard any vessel east of the COLREGS Line or to land more than 250 horseshoe crabs per day.

4. It shall be unlawful for any two horseshoe crab bycatch permittees fishing from the same boat or vessel, east of the COLREGS Line, to possess or land more than 500 horseshoe crabs per day.

4VAC20-900-30. License requirements and exemption.

A. It shall be unlawful for any person to harvest horseshoe crabs by hand for commercial purposes without first obtaining a commercial fisherman registration license and a horseshoe crab hand harvester license.

B. The taking by hand of as many as five horseshoe crabs in any one day for personal use only shall be exempt from the above licensing requirement.

C. Except as provided for in 4VAC20-900-25 G 3, it shall be unlawful for any boat or vessel to land horseshoe crabs in Virginia for commercial purposes without first obtaining a horseshoe crab endorsement license as described in this section. The horseshoe crab endorsement license shall be required of each boat or vessel used to land horseshoe crabs for commercial purposes. Possession of any quantity of horseshoe crabs that exceeds the limit described in subsection B of this section shall be presumed for commercial purposes. There shall be no fee for the license.

D. To be eligible for an unrestricted horseshoe crab endorsement license, the boat or vessel shall have landed and sold at least 500 horseshoe crabs in Virginia in at least one year during the period 1998-2000, except as described in subsection E of this section.

1. The owner shall complete an application for each boat or vessel by providing to the Marine Resources Commission a notarized and signed statement of applicant's name, address, telephone number, boat or vessel name and its registration or documentation number.

2. The owner shall complete a notarized authorization to allow the Marine Resources Commission to obtain copies of landings data from the National Marine Fisheries Service.

E. ~~Any Virginia registered commercial fisherman is eligible for a horseshoe crab endorsement license that is restricted to using a crab dredge to harvest horseshoe crabs provided his~~ To be eligible for a restricted horseshoe crab endorsement license that is limited to using a crab dredge to harvest horseshoe crabs, a Virginia registered commercial fisherman's boat or vessel shall have landed at least 10,000 pounds of whelk in any one year from 2002 through 2005.

1. The Virginia registered commercial fisherman shall complete an application for each boat or vessel by providing to the Marine Resources Commission a notarized and signed statement of the applicant's name, address, telephone number, boat or vessel name and its registration or documentation number.

2. The Virginia registered commercial fisherman shall complete a notarized authorization to allow the Marine Resources Commission to obtain copies of whelk landings data from the National Marine Fisheries Service.

4VAC20-900-35. Monitoring requirements.

A. Any person harvesting or landing horseshoe crabs in Virginia shall report monthly on forms provided by the Marine Resources Commission all harvests of horseshoe crabs including, but not limited to, bait fisheries, bycatch, biomedical industry, and scientific and educational research harvests. Reporting requirements shall consist of numbers and pounds landed by sex, harvest method and harvest location.

B. It shall be unlawful for a restricted or unrestricted horseshoe crab endorsement license holder to fail to contact the Marine Resources Operations Station prior to the vessel issued a horseshoe crab endorsement license offloading horseshoe crabs. The horseshoe crab endorsement license holder shall provide the Marine Resources Commission the name of the vessel and its captain and the anticipated or approximate offloading time and site. Following offloading, the horseshoe crab endorsement license holder shall contact the ~~Virginia Marine Resources Commission Interactive Voice Response (IVR) System within 24 hours of landing and provide his horseshoe crab endorsement license number; the time, date and location of offloading; and the number of horseshoe crabs landed~~ Marine Resources Operation Station and provide the total number of horseshoe crabs landed, gear type, and location of harvest.

C. It shall be unlawful for any horseshoe crab bycatch permittee to fail to contact the Virginia Marine Resources Commission Interactive-Voice-Response (IVR) System within 24 hours of landing and provide his Commercial Fisherman Registration License number, and the time, date, number of horseshoe crabs landed, gear type, and location of harvest.

D. It shall be unlawful for any person, firm or corporation to buy any horseshoe crabs from any lawful harvester on or after July 1, 2007, without first having obtained a Horseshoe Crab Buying Permit from the Marine Resources Commission. The permit application shall be completed in full by the licensed seafood buyer, and a copy of the permit shall be kept in possession of the licensed buyer while buying or possessing horseshoe crabs.

~~D.~~ E. Any licensed seafood buyer permitted to purchase horseshoe crabs shall provide written reports to the ~~commission~~ Marine Resources Commission of daily purchases and harvest information on forms provided by the ~~commission~~ Marine Resources Commission. Such information shall include the date of the purchase, the buyer's horseshoe crab permit number and harvester's Commercial Fisherman Registration License number, gear type used, water area fished, city or county of landing, and number of

female horseshoe crabs and male horseshoe crabs purchased. These reports of any current weekly purchases shall be completed in full and submitted to the ~~commission~~ Marine Resources Commission no later than Thursday of the following week. In addition, once it has been projected and announced that 85% of the commercial quota of horseshoe crab has been landed or 34% of the commercial quota of horseshoe crab established for the horseshoe crab harvest east of the COLREGS Line has been landed each permitted buyer shall call the ~~commission's interactive voice recording system~~ Marine Resources Commission's IVR on a daily basis to report his name and permit number, date, number of female horseshoe crabs and number of male horseshoe crabs purchased, gear used and water area fished by the harvester.

~~E.~~ F. Persons harvesting horseshoe crabs for biomedical use and owners of facilities using horseshoe crabs for biomedical purposes shall monitor and report monthly to the ~~commission~~ Marine Resources Commission all harvests or purchases of horseshoe crabs and the percentage of mortality up to the point of release including that mortality which occurs during harvest, shipping, handling, and bleeding.

~~F.~~ G. Owners of biomedical facilities using horseshoe crabs shall participate in the tagging program of the ~~commission~~ Marine Resources Commission to evaluate the post-release mortality of horseshoe crabs.

~~G.~~ H. Monthly reports shall be due to the ~~commission~~ Marine Resources Commission no later than the fifth day of the following month.

4VAC20-900-36. Quota allocation.

A. When it has been projected and announced that 42% of the commercial quota, as described in 4VAC20-900-25 D, has been landed by dredge gears, it shall be unlawful for any person to harvest or land horseshoe crabs by dredge gears.

B. When it has been projected and announced that 13% of the commercial quota, as described in 4VAC20-900-25 D, has been landed by trawl gears, it shall be unlawful for any person to harvest or land horseshoe crabs by trawl gears.

C. When it has been projected and announced that 23% of the commercial quota, as described in 4VAC20-900-25 D, has been landed by hand harvesting, it shall be unlawful for any person to harvest or land horseshoe crabs by hand harvesting.

D. When it has been projected and announced that 22% of the commercial quota, as described in 4VAC20-900-25 D, has been landed by gears not described in subsections A through C of this section, it shall be unlawful for any person to harvest or land horseshoe crabs by gears not described in subsections A through C of this section.

4VAC20-900-37. License moratorium.

As of May 1, 2011, the issuance of commercial licenses or permits for horseshoe crab hand harvest, horseshoe crab bycatch, unrestricted horseshoe crab endorsement, and restricted horseshoe crab endorsement shall be prohibited except as described in this section. Only those registered commercial fisherman who have been determined by the Marine Resources Commission to have been issued a license or permit prior to May 1, 2011, for horseshoe crab hand harvest, horseshoe crab bycatch, unrestricted horseshoe crab endorsement, or restricted horseshoe crab endorsement shall be eligible to purchase that license or permit after May 1, 2011.

4VAC20-900-38. Control date.

The Marine Resources Commission hereby establishes December 31, 2010, as the control date for management of all horseshoe crab licenses and fisheries in Virginia. Participation by any individual in a horseshoe crab fishery after the control date will not be considered in the calculation of horseshoe crabbing rights should further entry limitations be established. Any individual entering the horseshoe crab fishery after the control date will forfeit any right to future participation in the horseshoe crab fishery should further entry limitation be established.

4VAC20-900-40. Penalty.

As set forth in § 28.2-903 of the Code of Virginia, any person violating any provision of this ~~regulation~~ chapter shall be guilty of a Class 3 misdemeanor, and a second or subsequent violation of any provision of this ~~regulation~~ chapter committed by the same person within 12 months of a prior violation is a Class ~~I~~ 1 misdemeanor.

VA.R. Doc. No. R11-2830; Filed April 29, 2011, 11:11 a.m.

Final Regulation

Title of Regulation: **4VAC20-1230. Pertaining to Restrictions on Shellfish (amending 4VAC20-1230-10, 4VAC20-1230-20, 4VAC20-1230-30; repealing 4VAC20-1230-35).**

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

Effective Date: May 1, 2011.

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

Summary:

The amendments (i) require shellfish to be completely covered with a layer of ice; (ii) define a "layer" as a single thickness or coating spread out and covering a surface; and (iii) delete provisions regarding the identification of

shellfish as those provisions have been adopted as 4VAC20-1250, Pertaining to the Tagging of Shellfish.

4VAC20-1230-10. Purpose.

The purpose of this chapter is to establish ~~a method of identifying the original Virginia harvest area of any shellfish at any time of the year. In addition,~~ harvest times and handling procedures for shellfish harvested during the months of May through September, in order to protect the health of the public ~~are described herein~~.

4VAC20-1230-20. Definitions.

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

"Container" means any bag, sack, tote, or conveyance, such as a boat or truck, or other receptacle that contains shellfish to be held or transported.

"Harvest" means the act of removing any shellfish from a designated harvest area and placing that shellfish on or in a man-made conveyance or other means of transport.

"Layer" means a single thickness or coating spread out and covering a surface.

"Mechanical refrigeration" means storage in a container that is approved by the Virginia Department of Health Division of Shellfish Sanitation and capable of cooling to and maintaining an ambient temperature of 45°F or less.

"Oysters" ~~mean~~ means those oysters ~~greater than~~ 2-1/2 inches or greater in shell length.

"Seed clams" means those clams less than 30 mm in shell length and more than six months from harvest for human consumption.

"Seed oysters" mean those oysters less than 2-1/2 inches in shell length and more than six months from harvest for human consumption.

"Shading" means to shelter by intercepting the direct rays of the sun to protect the shellfish from heat using a tarp or cover.

"Shellfish" means all species of bivalve molluscan shellfish.

"Temperature control" means management of the environmental temperature, by means of ice or mechanical refrigeration, which is capable of lowering the temperature of the shellstock and maintaining it at 50°F (10°C) or less, as approved by the Virginia Department of Health (VDH), Division of Shellfish Sanitation.

4VAC20-1230-30. Public health and warm water harvest restrictions.

A. No provisions in this chapter shall apply to seed clams or seed oysters.

B. It shall be unlawful for any person to have any cat, dog, or other animal on board a vessel during the harvest of shellfish.

~~B.~~ C. From May 1 through September 30, any vessel used for the harvest of shellfish, from either public or private grounds, shall provide ~~adequate air flow through and~~ shading over the area that serves as storage for the shellfish when the shellfish are on board that vessel. All shellfish in the vessel shall be offloaded every day. Shading shall not be required for vessels transporting clam seed or seed oysters for replanting.

D. From May 1 through September 30, all shellfish shall be shaded during land-based deliveries.

~~C.~~ E. From May 1 through September 30, all land-based deliveries of shellfish requiring more than ~~30~~ 60 minutes ~~from landing that shellfish~~ after offloading is complete shall be made aboard trucks or conveyances equipped with mechanical refrigeration ~~having an ambient temperature of~~ capable of maintaining 45°F or less ~~before loading begins~~, except that shellfish may be ~~thoroughly iced~~ completely covered by a layer of ice, according to procedures approved by the ~~Virginia Department of Health (VDH)~~ VDH Division of Shellfish Sanitation. Mechanically refrigerated containers of shellfish shall be in operation ~~from the time of loading to the time of offloading~~ during transport. Any operator of a truck that is delivering shellfish using a truck not owned by a certified shellfish dealer shall possess a truck refrigeration certificate issued by the VDH Division of Shellfish Sanitation. Upon receipt of any shellfish at the shore-based plant, certified shellfish dealers must immediately place any shellfish received from the harvester under ~~mechanical refrigeration~~ temperature control.

~~D.~~ F. From June 15 through August 31, it shall be unlawful for any person ~~or person aboard a vessel~~ to leave the dock or shore, prior to one hour before sunrise, to harvest or attempt to harvest oysters from private grounds.

~~E.~~ G. From May 1 through June 14, it shall be unlawful for any person ~~or person aboard a vessel~~ to harvest oysters from public or private grounds after 11 a.m., and oysters harvested before 11 a.m. shall be ~~offloaded and~~ placed in VDH Division of Shellfish Sanitation-approved mechanical refrigeration or storage containers ~~with ice~~ and completely covered by a layer of ice by 11 a.m. that same day.

~~F.~~ H. From June 15 through August 31, it shall be unlawful for any person ~~or person aboard a vessel~~ to harvest oysters from public or private grounds after 10 a.m., and oysters harvested before 10 a.m. shall be ~~offloaded and~~ placed in VDH Division of Shellfish Sanitation-approved mechanical refrigeration or storage containers ~~with ice~~ and completely covered by a layer of ice by 10 a.m. that same day.

~~G.~~ I. From September 1 through September 30, it shall be unlawful for any person ~~or person aboard a vessel~~ to harvest

oysters from public or private grounds after noon, and oysters harvested before noon shall be ~~offloaded and~~ placed in VDH Division of Shellfish Sanitation-approved mechanical refrigeration or storage containers ~~with ice~~ and completely covered by a layer of ice by noon that same day.

~~H.~~ J. Except as described in subsections ~~K~~ L and ~~L~~ M of this section, oysters may be harvested after the designated harvesting time described in subsections ~~E, F, and~~ G, H, and I of this section, provided (i) the total time, from the time the vessel or harvester leaves the dock or shore until the oysters are ~~offloaded from the vessel and~~ placed in VDH Division of Shellfish Sanitation-approved mechanical refrigeration or ~~storage containers with ice~~ completely covered by a layer of ice in a storage container, shall not exceed five hours; (ii) there is a Virginia Marine Resources Commission-approved Global Positioning System tracking device on board the harvest vessel or with the harvester that is in continuous operation, from the time that vessel or harvester leaves the dock or shore until the vessel or harvester returns to the dock or shore and the oysters are offloaded from that vessel or onto the shore; and (iii) the harvester has applied for and been granted a permit by the Virginia Marine Resources Commission to harvest oysters after these designated harvesting times, and ~~the~~ that harvester has designated a ~~single~~ landing site for that permit.

~~I.~~ K. From May 1 through September 30, a Bulk Seed Permit shall be obtained from the Virginia Marine Resources Commission for the harvest of any natural (wild) seed oysters that ~~are~~ include oysters greater than 2-1/2 inches. Any person who harvests any natural (wild) seed oysters that include oysters greater than 2-1/2 inches and is not in possession of a Bulk Seed Permit issued by the Virginia Marine Resources Commission shall be in violation of this chapter.

~~J.~~ L. Any person may handle oysters as part of a cage aquaculture operation for husbandry purposes after the designated harvesting times described in subsections ~~E, F, and~~ G, H, and I of this section, provided that person possesses a valid Cage Aquaculture Husbandry Permit from the Virginia Marine Resources Commission. Any person who handles oysters in cage oyster aquaculture operations after the designated harvesting times described in subsections ~~E, F, and~~ G, H, and I of this section and does not possess a Cage Oyster Aquaculture Husbandry Permit issued by the Virginia Marine Resources Commission shall be in violation of this chapter.

~~K.~~ M. Oysters may be harvested in open areas of the James River and its adjacent tributaries, upstream from the Monitor Merrimac Memorial Bridge Tunnel, in addition to the designated harvesting times in subsections ~~E, F, and~~ G, H, and I of this section, provided (i) there is a VDH Division of Shellfish Sanitation-approved mechanical refrigeration ~~unit~~ or ice storage ~~area~~ container on board the harvesting vessel; (ii) the harvester has applied for and been issued a VDH Division of Shellfish Sanitation Vessel approval certificate that is required to be on board the vessel at all times during the harvest of oysters and has designated a ~~single~~ landing site for that permit; and (iii) the oysters are placed in ~~an operating refrigeration unit or~~ the VDH Division of Shellfish Sanitation-approved mechanical refrigeration in operation or an ice storage container with a layer of ice ~~is applied to~~ that completely covers the oysters from the start of harvest and throughout the harvest period until the oysters are offloaded.

4VAC20-1230-35. ~~Shellfish identification.~~ (Repealed.)

~~A. Any person harvesting shellfish for commercial purposes shall affix a tag to each container of shellfish before the shellfish are removed from that harvester's boat. The shellfish tag shall remain in place while the shellfish are transported to a certified dealer and shall remain affixed to each container of shellfish until the container is emptied or shipped and retagged by a dealer. For any quantities of harvested shellfish sold in bulk that are loose and not containerized aboard a boat, the harvester shall prepare a single tag for that quantity of shellfish that shall accompany that quantity of shellfish during transport, from the landing site to the dealer facilities.~~

~~B. The shellfish tag shall be durable, waterproof, and approved by the Marine Resources Commission, prior to use, and shall be at least 13.8 square inches in size.~~

~~C. The shellfish tag shall contain all of the following indelible and legible information, in the following order:~~

~~1. The harvester's VMRC identification number (last four digits) or VMRC oyster aquaculture harvester permit number or clam aquaculture harvester permit number;~~

~~2. The date of harvest;~~

~~3. The most accurate identification of the harvest location or aquaculture site, including the abbreviated name of the state of harvest and the commission's designation of the growing area by indexing, administrative, or geographic designation;~~

~~4. The type and quantity of harvested shellfish; and~~

~~5. The following statement, in bold capitalized letters: "THIS TAG IS REQUIRED TO BE ATTACHED UNTIL THE CONTAINER IS EMPTY OR IS RETAGGED AND THEREAFTER KEPT ON FILE FOR 90 DAYS."~~

~~D. When multiple containers of shellfish are harvested from a single harvest area in any one day and placed in a bulk container, the lot may be tagged with a single bulk tag that shall accompany the shellfish during transport from the landing site to the dealer facility. In addition to the information required in subsection C of this section, the bulk tag shall also include:~~

~~1. The following statement in bold capitalized letters: "ALL SHELLFISH CONTAINERS IN THIS LOT HAVE~~

~~THE SAME HARVEST DATE AND AREA OF HARVEST" and~~

~~2. The number of individual containers in the lot.~~

VA.R. Doc. No. R11-2828; Filed April 29, 2011, 10:36 a.m.

Final Regulation

Title of Regulation: **4VAC20-1250. Pertaining to the Tagging of Shellfish (adding 4VAC20-1250-10 through 4VAC20-1250-40).**

Statutory Authority: §§ 28.2-201 and 28.2-801 of the Code of Virginia.

Effective Date: May 1, 2011.

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

Summary:

The amendments establish the use and assorted requirements for identification tags for tracking shellfish from point of origin to the final destination.

CHAPTER 1250
PERTAINING TO THE TAGGING OF SHELLFISH

4VAC20-1250-10. Purpose.

The purpose of this chapter is to establish a method of identifying harvested shellfish according to its original Virginia harvest area at any time of the year.

4VAC20-1250-20. Definitions.

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

"Container" means any bag, sack, tote, or conveyance, such as a boat or truck, or other receptacle that contains shellfish to be held or transported.

"Harvest" means the act of removing any shellfish from a designated harvest area and placing that shellfish on or in a man-made conveyance or other means of transport.

"Oysters" means those oysters 2-1/2 inches or greater in shell length.

"Shellfish" means all species of bivalve molluscan shellfish.

4VAC20-1250-30. Shellfish identification.

A. Any person harvesting shellfish for commercial purposes shall affix a tag to each container of shellfish as soon as possible after leaving any harvest area but before harvesting shellfish from another harvest area or offloading the shellfish. The shellfish tag shall remain in place while the shellfish are transported to a certified dealer and shall remain affixed to each container of shellfish until the container is emptied or shipped and re-tagged by a dealer. For any quantities of harvested shellfish sold in bulk that are loose and not containerized aboard a boat, the harvester shall prepare a single tag, for that quantity of shellfish, which shall accompany that quantity of shellfish during transport from the landing site to the dealer facilities.

B. The shellfish tag shall be durable, waterproof, and approved by the Marine Resources Commission (VMRC) or the Virginia Department of Health (VDH) prior to use, and shall be at least 13.8 square inches in size.

C. The shellfish tag shall contain all of the following indelible and legible information, in the following order:

1. The harvester's VMRC identification number (last four digits) or VMRC oyster aquaculture harvester permit number or clam aquaculture harvester permit number or VDH Certificate of Inspection number;

2. The date of harvest;

3. The most accurate identification of the harvest location or aquaculture site, including the abbreviated name of the state of harvest and the commission's designation of the growing area by indexing, administrative, or geographic designation;

4. The type and quantity of harvested shellfish; and

5. The following statement, in bold capitalized letters: "THIS TAG IS REQUIRED TO BE ATTACHED, UNTIL THE CONTAINER IS EMPTY OR IS RE-TAGGED, AND THEREAFTER KEPT ON FILE FOR 90 DAYS."

D. When multiple containers of shellfish are harvested from a single harvest area, in any one day, and placed in a bulk container, the lot may be tagged with a single bulk tag that shall accompany the shellfish during transport from the landing site to the dealer facility. In addition to the information required in subsection C of this section, the bulk tag shall also include:

1. The following statement in bold capitalized letters: "ALL SHELLFISH CONTAINERS IN THIS LOT HAVE THE SAME HARVEST DATE AND AREA OF HARVEST"; and

2. The number of individual containers in the lot.

E. Whenever any shellfish are harvested, whether loose, in bulk, or in containers, and are not tagged as required by subsection C of this section, this shall constitute a violation of this chapter, and the entire quantity of untagged shellfish shall be subject to seizure and disposed of in accordance with 4VAC20-1250-40.

4VAC20-1250-40. Penalty.

A. In addition to the penalty prescribed by law, any person violating any provision of this chapter shall destroy, in the presence of a marine police officer, all shellfish in his possession, or, at the direction of the marine police officer, shall place the shellfish overboard on the nearest oyster sanctuary or closed shellfish area and shall cease harvesting on that day. All harvesting apparatus may be subject to seizure, and, pursuant to § 28.2-232 of the Code of Virginia, all licenses and permits may be subject to revocation, following a hearing before the Virginia Marine Resources Commission.

B. As set forth in § 28.2-903 of the Code of Virginia, any person violating any provision of this chapter shall be guilty of a Class 3 misdemeanor, and a second or subsequent violation of any provision of this chapter committed by the same person, within 12 months of a prior violation, is a Class 1 misdemeanor.

VA.R. Doc. No. R11-2726; Filed April 29, 2011, 10:22 a.m.

◆ ◆

TITLE 9. ENVIRONMENT

STATE WATER CONTROL BOARD

Proposed Regulation

REGISTRAR'S NOTICE: The following regulation filed by the State Water Control Board is exempt from the Administrative Process Act in accordance with § 2.2-4006 A 8 of the Code of Virginia, which exempts general permits issued by the State Water Control Board pursuant to the State Water Control Law (§ 62.1-44.2 et seq.), Chapter 24 (§ 62.1-242 et seq.) of Title 62.1, and Chapter 25 (§ 62.1-254 et seq.) of Title 62.1 if the board (i) provides a Notice of Intended Regulatory Action in conformance with the provisions of § 2.2-4007.01; (ii) following the passage of 30 days from the publication of the Notice of Intended Regulatory Action forms a technical advisory committee composed of relevant stakeholders, including potentially affected citizens groups, to assist in the development of the general permit; (iii) provides notice and receives oral and written comment as provided in § 2.2-4007.03; and (iv) conducts at least one public hearing on the proposed general permit.

Title of Regulation: **9VAC25-820. General Virginia Pollutant Discharge Elimination System (VPDES) Watershed Permit Regulation for Total Nitrogen and Total Phosphorus Discharges and Nutrient Trading in the Chesapeake Bay Watershed in Virginia (amending 9VAC25-820-10, 9VAC25-820-40, 9VAC25-820-70; adding 9VAC25-820-80).**

Statutory Authority: § 62.1-44.15 of the Code of Virginia.

Public Hearing Information:

July 6, 2011 - 3 p.m. - Department of Environmental Quality, Piedmont Regional Office, 4949-A Cox Road, Glen Allen, VA

Public Comment Deadline: July 22, 2011.

Agency Contact: Allan Brockenbrough, Department of Environmental Quality, 629 East Main Street, P.O. Box 1105, Richmond, VA 23218, telephone (804) 698-4147, FAX (804) 698-4032, or email allan.brockenbrough@deq.virginia.gov.

Summary:

This action amends and reissues the existing general permit for total nitrogen (TN) and total phosphorus (TP) discharges and nutrient trading in the Chesapeake Bay watershed in Virginia. The regulation provides for the permitting of TN and TP discharges in the Chesapeake Bay watershed and allows for trading of nutrient credits to minimize costs to the regulated facilities and allow for future growth.

In accordance with § 62.1-44.19:14 of the Code of Virginia, the general permit includes (i) waste load allocations for TN and TP for each permitted facility expressed as annual mass loads; (ii) a schedule requiring compliance with the waste load allocations as soon as possible for any facility whose waste load allocation was reduced by the December 29, 2010, Chesapeake Bay total maximum daily load (TMDL); (iii) monitoring and reporting requirements; (iv) a procedure requiring affected owners or operators to secure general permit coverage; (v) a procedure for efficiently modifying the list of facilities covered by the general permit; and (vi) such other conditions as the board deems necessary to carry out the provisions of state and federal law.

Changes made to the existing regulation include (i) reduced TN and TP waste load allocations for the Hampton Roads Sanitation District facilities on the James River and reduced TP allocations for all facilities in the York Basin along with appropriate schedules of compliance; (ii) a new aggregate, Chlorophyl a-based TN and TP waste load allocation for the significant James River dischargers with a compliance deadline of January 1, 2023; (iii) extending the registration deadline one month to November 1, 2011; (iv) allowing for coverage under the general permit to be administratively continued, if necessary; (v) correcting inaccuracies introduced by previous requirements to calculate loads based on flows expressed to the nearest 0.01 MGD and to round nutrient loads to the nearest whole pound on a daily basis; (vi) establishing a baseline condition for offsets generated by new stormwater best management practices; (vii) updated prices of TN and TP credit purchases from the Water Quality Improvement Fund based on the cost of projects financed by the fund over the previous permit cycle; (viii)

requiring that offsets required for the full five-year term of the permit be provided at the time of registration; (ix) provisions to implement a number of laws addressing nutrient trading that have become effective since the original regulation was adopted; and (x) updated TN and TP delivery factors.

9VAC25-820-10. Definitions.

Except as defined below, the words and terms used in this chapter shall have the meanings defined in the Virginia Pollution Discharge Elimination System (VPDES) Permit Regulation (9VAC25-31).

"Annual mass load of total nitrogen" (expressed in pounds per year) means ~~the daily total nitrogen concentration (expressed as mg/l to the nearest 0.01 mg/l) multiplied by the flow volume of effluent discharged during the 24 hour period (expressed as MGD to the nearest 0.01 MGD), multiplied by 8.3438 and rounded to the nearest whole number to convert to pounds per day (lbs/day) units, then totaled for the calendar month to convert to pounds per month (lbs/mo) units, and then totaled for the calendar year to convert to pounds per year (lbs/yr) units~~ the sum of the total monthly loads for all of the months in one calendar year. See Part I E 4 of the general permit in 9VAC25-820-70 for calculating total monthly load.

"Annual mass load of total phosphorus" (expressed in pounds per year) means ~~the daily total phosphorus concentration (expressed as mg/l to the nearest 0.01mg/l) multiplied by the flow volume of effluent discharged during the 24 hour period (expressed as MGD to the nearest 0.01 MGD) multiplied by 8.3438 and rounded to the nearest whole number to convert to pounds per day (lbs/day) units, then totaled for the calendar month to convert to pounds per month (lbs/mo) units, and then totaled for the calendar year to convert to pounds per year (lbs/yr) units~~ the sum of the total monthly loads for all of the months in one calendar year. See Part I E 4 of the general permit in 9VAC25-820-70 for calculating total monthly load.

"Association" means the Virginia Nutrient Credit Exchange Association authorized by § 62.1-44.19:17 of the Code of Virginia.

"Attenuation" means the rate at which nutrients are reduced through natural processes during transport in water.

"Biological nutrient removal technology" means (i) technology that will achieve an annual average total nitrogen effluent concentration of eight milligrams per liter and an annual average total phosphorus effluent concentration of one milligram per liter, or (ii) equivalent reductions in loads of total nitrogen and total phosphorus through the recycle or reuse of wastewater as determined by the department.

"Board" means the Virginia State Water Control Board or State Water Control Board.

"Delivered total nitrogen load" means the discharged mass load of total nitrogen from a point source that is adjusted by the delivery factor for that point source.

"Delivered total phosphorus load" means the discharged mass load of total phosphorus from a point source that is adjusted by the delivery factor for that point source.

"Delivery factor" means an estimate of the number of pounds of total nitrogen or total phosphorus delivered to tidal waters for every pound discharged from a permitted facility, as determined by the specific geographic location of the permitted facility, to account for attenuation that occurs during riverine transport between the permitted facility and tidal waters. Delivery factors shall be calculated using the Chesapeake Bay Program watershed model. For the purpose of this regulation, delivery factors with a value greater than 1.00 in the Chesapeake Bay Program watershed model shall be considered to be equal to 1.00.

"Department" means the Department of Environmental Quality.

"Eastern Shore trading ratio" means the number of point source credits from another tributary that can be used to compensate for excessive loads from a facility in the Eastern Shore Basin. Trading ratios are expressed in the form "credits supplied: credits received."

"Equivalent load" means:

2,300 pounds per year of total nitrogen or 300 pounds per year of total phosphorus discharged by an industrial facility are considered equivalent to the load discharged from sewage treatment works with a design capacity of 0.04 million gallons per day,

5,700 pounds per year of total nitrogen or 760 pounds per year of total phosphorus discharged by an industrial facility are considered equivalent to the load discharged from sewage treatment works with a design capacity of 0.1 million gallons per day, and

28,500 pounds per year of total nitrogen or 3,800 pounds per year of total phosphorus discharged by an industrial facility are considered equivalent to the load discharged from sewage treatment works with a design capacity of 0.05 million gallons per day.

"Existing facility" means a facility holding a current individual VPDES permit that has either commenced discharge from, or has received a Certificate to Construct (for sewage treatment works, or equivalent DEQ approval for discharges from industrial facilities) the treatment works used to derive its waste load waste load allocation on or before July 1, 2005, or has a ~~wasteload~~ waste load allocation listed in 9VAC25-720-50 C, 9VAC25-720-60 C, 9VAC25-720-70 C, 9VAC25-720-110 C, and 9VAC25-720-120 C of the Water Quality Management Planning Regulation. Existing facility shall also mean and include any facility, without an

individual VPDES permit, which holds a separate waste load allocation in 9VAC25-720-120 C of the Water Quality Management Planning Regulation.

"Expansion" or "expands" means (i) initiating construction at an existing treatment works after July 1, 2005, to increase design flow capacity, except that the term does not apply in those cases where a Certificate to Construct (for sewage treatment works, or equivalent DEQ approval for discharges from industrial facilities) was issued on or before July 1, 2005, or (ii) industrial production process changes or the use of new treatment products at industrial facilities that increase the annual mass load of total nitrogen or total phosphorus.

"Facility" means a point source discharging or proposing to discharge total nitrogen or total phosphorus to the Chesapeake Bay or its tributaries. This term does not include confined animal feeding operations, discharges of storm water, return flows from irrigated agriculture, or vessels.

"General permit" means this general permit authorized by § 62.1-44.19:14 of the Code of Virginia.

"Industrial facility" means any facility (as defined above) other than sewage treatment works.

"New discharge" means any discharge from a facility that did not commence the discharge of pollutants prior to July 1, 2005, except that the term does not apply in those cases where a Certificate to Construct (for sewage treatment works, or equivalent DEQ approval for discharges from industrial facilities) was issued to the facility on or before July 1, 2005.

"Local water quality-based limitations" means limitations intended to protect local water quality including applicable total maximum daily load (TMDL) allocations, applicable Virginia Pollution Discharge Elimination System (VPDES) permit limits, applicable limitations set forth in water quality standards established under § 62.1-44.15 (3a) of the Code of Virginia, or other limitations as established by the State Water Control Board.

"Nonsignificant discharger" means (i) a sewage treatment works discharging to the Chesapeake Bay watershed downstream of the fall line with a design capacity of less than 0.1 million gallons per day, or less than an equivalent load discharged from industrial facilities, or (ii) a sewage treatment works discharging to the Chesapeake Bay watershed upstream of the fall line with a design capacity of less than 0.5 million gallons per day, or less than an equivalent load discharged from industrial facilities.

"Offset" means to acquire an annual waste load allocation of total nitrogen or total phosphorus by a new or expanding facility to ensure that there is no net increase of nutrients into the affected tributary of the Chesapeake Bay.

~~"Permitted facility" means a facility authorized by this general permit to discharge total nitrogen or total phosphorus. For the sole purpose of generating point source nitrogen credits or point source phosphorus credits, "permitted facility" shall also mean the Blue Plains wastewater treatment facility operated by the District of Columbia Water and Sewer Authority.~~

"Permitted design capacity" or "permitted capacity" means the allowable load (pounds per year) assigned to an existing facility that is a nonsignificant discharger, that does not have a ~~wasteload~~ waste load allocation listed in 9VAC25-720-50 C, 9VAC25-720-60 C, 9VAC25-720-70 C, 9VAC25-720-110 C, and 9VAC25-720-120 C of the Water Quality Management Planning Regulation. The permitted design capacity is calculated based on the design flow and installed nutrient removal technology (for sewage treatment works, or equivalent discharge from industrial facilities) at a facility that has either commenced discharge, or has received a Certificate to Construct (for sewage treatment works, or equivalent DEQ approval for discharges from industrial facilities) prior to July 1, 2005. This mass load is used for (i) determining whether the expanding facility must offset additional mass loading of nitrogen and phosphorus and (ii) determining whether the facility must acquire credits at the end of a calendar year. For the purpose of this regulation, facilities that have installed secondary wastewater treatment (intended to achieve BOD and TSS monthly average concentrations equal to or less than 30 milligrams per liter) are assumed to achieve an annual average total nitrogen effluent concentration of 18.7 milligrams per liter and an annual average total phosphorus effluent concentration of 2.5 milligrams per liter. Permitted design capacities for facilities that, before July 1, 2005, were required to comply with more stringent nutrient limits shall be calculated using the more stringent values.

"Permitted facility" means a facility authorized by this general permit to discharge total nitrogen or total phosphorus. For the sole purpose of generating point source nitrogen credits or point source phosphorus credits, "permitted facility" shall also mean the Blue Plains wastewater treatment facility operated by the District of Columbia Water and Sewer Authority.

"Permittee" means a person authorized by this general permit to discharge total nitrogen or total phosphorus.

"Point source nitrogen credit" means the difference between (i) the waste load allocation for a permitted facility specified as an annual mass load of total nitrogen and (ii) the monitored annual mass load of total nitrogen discharged by that facility, that clause (ii) is less than clause (i), and where the difference is adjusted by the applicable delivery factor and expressed as pounds per year of delivered total nitrogen load.

"Point source phosphorus credit" means the difference between (i) the waste load allocation for a permitted facility specified as an annual mass load of total phosphorus and (ii) the monitored annual mass load of total phosphorus discharged by that facility, where clause (ii) is less than

clause (i), and where the difference is adjusted by the applicable delivery factor and expressed as pounds per year of delivered total phosphorus load.

"Quantification level (QL)" means the ~~lowest standard in the calibration curve for a given analyte. The QL must have a value greater than zero and be verified each day of analysis by analyzing a sample of known concentration at the selected QL with a recovery range of 70% – 130%~~ minimum levels, concentrations, or quantities of a target variable (e.g., target analyte) that can be reported with a specified degree of confidence in accordance with 1VAC30-45, Certification for Noncommercial Environmental Laboratories, or 1VAC30-46, Accreditation for Commercial Environmental Laboratories.

"Registration list" means a list maintained by the department indicating all facilities that have registered for coverage under this general permit, by tributary, including their waste load allocations, permitted design capacities and delivery factors as appropriate.

"Significant discharger" means (i) a sewage treatment works discharging to the Chesapeake Bay watershed upstream of the fall line with a design capacity of 0.5 million gallons per day or greater, or an equivalent load discharged from industrial facilities; (ii) a sewage treatment works discharging to the Chesapeake Bay watershed downstream of the fall line with a design capacity of 0.1 million gallons per day or greater, or an equivalent load discharged from industrial facilities; (iii) a planned or newly expanding sewage treatment works discharging to the Chesapeake Bay watershed upstream of the fall line that is expected to be in operation by December 31, 2010, with a permitted design of 0.5 million gallons per day or greater, or an equivalent load to be discharged from industrial facilities; or (iv) a planned or newly expanding sewage treatment works discharging to the Chesapeake Bay watershed downstream of the fall line that is expected to be in operation by December 31, 2010, with a design capacity of 0.1 million gallons per day or greater, or an equivalent load to be discharged from industrial facilities.

"State-of-the-art nutrient removal technology" means (i) technology that will achieve an annual average total nitrogen effluent concentration of three milligrams per liter and an annual average total phosphorus effluent concentration of 0.3 milligrams per liter or (ii) equivalent load reductions in total nitrogen and total phosphorus through recycle or reuse of wastewater as determined by the department.

"Tributaries" means those river basins for which separate tributary strategies were prepared pursuant to § 2.2-218 of the Code of Virginia and includes the Potomac, Rappahannock, York, and James River Basins, and the Eastern Coastal Basin, which encompasses the creeks and rivers of the Eastern Shore of Virginia that are west of Route 13 and drain into the Chesapeake Bay.

"Waste load allocation" means (i) the water quality-based annual mass load of total nitrogen or annual mass load of total phosphorus allocated to individual facilities pursuant to 9VAC25-720-50 C, 9VAC25-720-60 C, 9VAC25-720-70 C, 9VAC25-720-110 C, and 9VAC25-720-120 C of the Water Quality Management Planning Regulation or its successor, (ii) the water quality-based annual mass load of total nitrogen or annual mass load of total phosphorus acquired pursuant to § 62.1-44.19:15 of the Code of Virginia for new or expanded facilities, or (iii) applicable total nitrogen or total phosphorus total maximum daily loads to restore or protect the water quality and beneficial uses of the Chesapeake Bay or its tidal tributaries.

9VAC25-820-40. Compliance plans.

~~A. Within nine months of the effective date of this regulation, every owner or operator of a facility required to submit a registration statement to the department by January 1, 2007,~~ By July 1, 2012, every owner or operator of a facility subject to reduced individual total nitrogen or total phosphorus waste load allocations in the Chesapeake Bay Total Maximum Daily Load for Nitrogen, Phosphorus and Sediment dated December 29, 2010, (as identified in 9VAC25-820-80) shall either individually or through the Virginia Nutrient Credit Exchange Association submit compliance plans to the department for approval.

1. The compliance plans shall contain any capital projects and implementation schedules needed to achieve total nitrogen and phosphorus reductions sufficient to comply with the individual and combined waste load allocations of all the permittees in the tributary as soon as possible. Permittees submitting individual plans are not required to account for other facilities' activities.

2. As part of the compliance plan development, permittees ~~whose facilities would have complied with their individual waste load allocations for calendar year 2005, had the allocations been effective in that year,~~ shall either:

a. Demonstrate that the additional capital projects in subdivision 1 of this subsection are necessary to ensure continued compliance with these allocations through the applicable deadline for the tributary to which the facility discharges (Part I C of the permit), or

b. Request that their individual waste load allocations become effective on January 1, ~~2007~~ 2012. ~~Permittees selecting this option shall be entitled to trade nutrient credits generated by their facilities and to acquire nutrient credits.~~

3. The compliance plans may rely on the exchange of point source credits in accordance with this general permit, but not the acquisition of credits through payments into the Water Quality Improvement Fund (§ 10.1-2128 et seq. of the Code of Virginia), to achieve compliance with the

individual and combined waste load allocations in each tributary.

B. Every owner or operator of a facility required to submit a registration statement shall either individually or through the Virginia Nutrient Credit Exchange Association submit annual compliance plan updates to the department for approval as required by Part I D of this general permit.

9VAC25-820-70. General permit.

Any owner whose registration statement is accepted by the board will receive the following general permit and shall comply with the requirements therein.

General Permit No.: VAN000000

Effective Date: January 1, ~~2007~~ 2012

Expiration Date: December 31, ~~2011~~ 2016

GENERAL PERMIT FOR TOTAL NITROGEN AND TOTAL PHOSPHORUS DISCHARGES AND NUTRIENT TRADING IN THE CHESAPEAKE WATERSHED IN VIRGINIA

AUTHORIZATION TO DISCHARGE UNDER THE VIRGINIA POLLUTANT DISCHARGE ELIMINATION SYSTEM AND THE VIRGINIA STATE WATER CONTROL LAW

In compliance with the provisions of the Clean Water Act, as amended, and pursuant to the State Water Control Law and regulations adopted pursuant thereto, owners of facilities holding a VPDES individual permit or owners of facilities that otherwise meet the definition of an existing facility, with total nitrogen and/or total phosphorus discharges to the Chesapeake Bay or its tributaries, are authorized to discharge to surface waters and exchange credits for total nitrogen and/or total phosphorus.

The authorized discharge shall be in accordance with the registration statement filed with DEQ, this cover page, Part I-Special Conditions Applicable to All Facilities, Part II-Special Conditions Applicable to New and Expanded Facilities, and Part III-Conditions Applicable to All VPDES Permits, as set forth herein.

Part I
Special Conditions Applicable To All Facilities

A. Authorized activities.

1. Authorization to discharge for facilities required to register.

a. Every owner or operator of a facility required to submit a registration statement to the department by ~~January 1, 2007~~ November 1, 2011, and thereafter upon the reissuance of this general permit, shall be authorized to discharge total nitrogen and total phosphorus subject to the requirements of this general permit upon the department's approval of the registration statement.

b. Any owner or operator of a facility required to submit a registration statement with the department at the time he makes application with the department for a new discharge or expansion that is subject to an offset or technology-based requirement in Part II of this general permit, shall be authorized to discharge total nitrogen and total phosphorus subject to the requirements of this general permit upon the department's approval of the registration statement.

c. Upon the department's approval of the registration statement, a facility will be included in the registration list maintained by the department.

2. Authorization to discharge for facilities not required to register. Any facility authorized by a Virginia Pollutant Discharge Elimination System permit and not required by this general permit to submit a registration statement shall be deemed to be authorized to discharge total nitrogen and total phosphorus under this general permit at the time it is issued. Owners or operators of facilities that are deemed to be permitted under this subsection shall have no obligation under this general permit prior to submitting a registration statement and securing coverage under this general permit based upon such registration statement.

3. Continuation of permit coverage.

a. Any owner authorized to discharge under this general permit and who submits a complete registration statement for the reissued general permit by November 1, 2016, in accordance with Part III A or who is not required to register in accordance with Part I A 2 is authorized to continue to discharge under the terms of this general permit until such time as the board either:

(1) Issues coverage to the owner under the reissued general permit, or

(2) Notifies the owner that coverage under the reissued permit is denied.

b. When the owner that was covered under the expiring or expired general permit has violated or is violating the conditions of that permit, the board may choose to do any or all of the following:

(1) Initiate enforcement action based upon the general permit that has been continued,

(2) Issue a notice of intent to deny coverage under the amended general permit if the general permit coverage is denied the owner would then be required to cease the activities authorized by the continued general permit or be subject to enforcement action for operating without a permit, or

(3) Take other actions authorized by the State Water Control Law.

B. Waste load allocations.

1. Waste load allocations allocated to permitted facilities pursuant to 9VAC25-720-50 C, 9VAC25-720-60 C, 9VAC25-720-70 C, 9VAC25-720-110 C, and 9VAC25-720-120 C of the Water Quality Management Planning Regulation, or applicable total maximum daily loads, or waste load allocations acquired by new and expanding facilities to offset new or increased delivered total nitrogen and delivered total phosphorus loads from a new discharge or expansion under Part II B of this general permit, and existing loads calculated from the permitted design capacity of expanding facilities not previously covered by this general permit, shall be incorporated into the registration list maintained by the department. The waste load allocations contained in this list shall be enforceable as annual mass load limits in this general permit. Credits shall not be generated by facilities whose mass loads are derived from permitted design capacities, or from facilities whose operations were previously authorized by a Virginia Pollution Abatement (VPA) permit that was issued before July 1, 2005.

2. Except as described in ~~subdivision~~ subdivisions 2 d and 2 e of this subsection, an owner or operator of two or more facilities covered by this general permit and located in the same tributary may apply for and receive an aggregated mass load limit for delivered total nitrogen and an aggregated mass load limit for delivered total phosphorus reflecting the total of the water quality-based total nitrogen and total phosphorus waste load allocations or permitted design capacities established for such facilities individually.

a. The permittee (and all of the individual facilities covered under a single registration) shall be deemed to be in compliance when the aggregate mass load discharged by the facilities is less than the aggregate load limit.

b. The permittee will be eligible to generate credits only if the aggregate mass load discharged by the facilities is less than the total of the waste load allocations assigned to any of the affected facilities in 9VAC25-720-50 C, 9VAC25-720-60 C, 9VAC25-720-70 C, 9VAC25-720-110 C and 9VAC25-720-120 C of the Water Quality Management Planning Regulation.

c. Credits shall not be generated by permittees whose aggregated mass load limit is derived entirely from permitted design capacities.

d. The aggregation of mass load limits shall not affect any requirement to comply with local water quality-based limitations.

e. Facilities whose operations were previously authorized by a Virginia Pollution Abatement (VPA) permit that was issued before July 1, 2005, cannot be aggregated with other facilities under common ownership or operation.

f. Operation under an aggregated mass load limit in accordance with this section shall not be deemed credit acquisition as described in Part I J 2 of this general permit.

3. An owner who consolidates two or more facilities located in the same tributary into a single regional facility may apply for and receive an aggregated mass load limit for delivered total nitrogen and an aggregated mass load limit for delivered total phosphorus, subject to the following conditions:

a. If all of the affected facilities have waste load allocations in 9VAC25-720-50 C, 9VAC25-720-60 C, 9VAC25-720-70 C, 9VAC25-720-110 C, and 9VAC25-720-120 C of the Water Quality Management Planning Regulation, the aggregate mass load limit shall be calculated by adding the waste load allocations of the affected facilities. The regional facility shall be eligible to generate credits.

b. If any, but not all, of the affected facilities has a waste load allocation in 9VAC25-720-50 C, 9VAC25-720-60 C, 9VAC25-720-70 C, 9VAC25-720-110 C, and 9VAC25-720-120 C of the Water Quality Management Planning Regulation, the aggregate mass load limit shall be calculated by adding:

(1) Waste load allocations of those facilities that have ~~wasteload~~ waste load allocations in 9VAC25-720-50 C, 9VAC25-720-60 C, 9VAC25-720-70 C, 9VAC25-720-110 C, and 9VAC25-720-120 C of the Water Quality Management Planning Regulation;

(2) Permitted design capacities assigned to affected industrial facilities; and

(3) Loads from affected sewage treatment works that do not have a waste load allocation in 9VAC25-720-50 C, 9VAC25-720-60 C, 9VAC25-720-70 C, 9VAC25-720-110 C, and 9VAC25-720-120 C of the Water Quality Management Planning Regulation, defined as the lesser of a previously calculated permitted design capacity, or the values calculated by the following formulae:

Nitrogen Load (lbs/day) = flow ~~(expressed as MGD to the nearest 0.01 MGD)~~ x 8.0 mg/l x ~~8.3438~~ 8.345 x 365 days/year

Phosphorus Load (lbs/day) = flow ~~(expressed as MGD to the nearest 0.01 MGD)~~ x 1.0 mg/l x ~~8.3438~~ 8.345 x 365 days/year

Flows used in the preceding formulae shall be the design flow of the treatment works from which the affected facility currently discharges.

The regional facility shall be eligible to generate credits.

c. If none of the affected facilities have a waste load allocation in 9VAC25-720-50 C, 9VAC25-720-60 C, 9VAC25-720-70 C, 9VAC25-720-110 C, and 9VAC25-720-120 C of the Water Quality Management Planning Regulation, the aggregate mass load limit shall be calculated by adding the respective permitted design capacities for the affected facilities. The regional facility shall not be eligible to generate credits.

d. Facilities whose operations were previously authorized by a Virginia Pollution Abatement (VPA) permit that was issued before July 1, 2005, may be consolidated with other facilities under common ownership or operation, but their allocations cannot be transferred to the regional facility.

e. Facilities whose operations were previously authorized by a VPA permit that was issued before July 1, 2005, can become regional facilities, but they cannot receive additional allocations beyond those permitted in Part II B 1 d of this general permit.

4. Unless otherwise noted, the nitrogen and phosphorus waste load allocations assigned to permitted facilities are considered total loads including nutrients present in the intake water from the river, as applicable. On a case-by-case basis, an industrial discharger may demonstrate to the satisfaction of the board that a portion of the nutrient load originates in its intake water. This demonstration shall be consistent with the assumptions and methods used to derive the allocations through the Chesapeake Bay models. In these cases, the board may limit the permitted discharge to the net nutrient load portion of the assigned waste load allocation.

5. Bioavailability. Unless otherwise noted, the entire nitrogen and phosphorus waste load allocations assigned to permitted facilities are considered to be bioavailable to organisms in the receiving stream. On a case-by-case basis, a discharger may demonstrate to the satisfaction of the board that a portion of the nutrient load is not bioavailable; this demonstration shall not be based on the ability of the nutrient to resist degradation at the wastewater treatment plant, but instead, on the ability of the nutrient to resist degradation within a natural environment for the amount of time that it is expected to remain in the bay watershed. This demonstration shall also be consistent with the assumptions and methods used to derive the allocations through the Chesapeake Bay models. In these cases, the board may limit the permitted discharge to the bioavailable portion of the assigned waste load allocation.

C. Schedule of compliance.

1. The following schedule of compliance pertaining to the load allocations for total nitrogen and total phosphorus applies to the facilities listed in ~~each tributary, as listed~~ 9VAC25-820-80.

a. Compliance shall be achieved as soon as possible, but no later than the following dates, subject to any compliance plan-based adjustment by the board pursuant to subdivision 1 b of this subsection, for each parameter:

Tributary	Parameter	Final Effluent Limits Effective Date
James River	Nitrogen ~~Phosphorus~~	~~January 1, 2011~~ January 1, 2017 ~~January 1, 2011~~
~~Shenandoah and Potomac Rivers~~	~~Nitrogen~~ ~~Phosphorus~~	~~January 1, 2011~~ ~~January 1, 2011~~
~~Rappahannock River~~	~~Nitrogen~~ ~~Phosphorus~~	~~January 1, 2011~~ ~~January 1, 2011~~
York River	~~Nitrogen~~ Phosphorus	~~January 1, 2011~~ ~~January 1, 2011~~ January 1, 2016
~~Eastern Shore~~	~~Nitrogen~~ ~~Phosphorus~~	~~January 1, 2011~~ ~~January 1, 2011~~

b. Following submission of compliance plans and compliance plan updates required by 9VAC25-820-40, the board shall reevaluate the schedule of compliance in subdivision 1 a of this subsection, taking into account the information in the compliance plans and the factors in § 62.1-44.19:14 C 2 of the Code of Virginia. When warranted based on such information and factors, the board shall adjust the schedule in subdivision 1 a of this subsection as appropriate by modification or reissuance of this general permit.

2. The registration list shall contain individual dates for compliance (as defined in Part I J 1 a-b of this general permit) for dischargers, as follows:

a. Facilities ~~that were required to submit a registration statement with the department by January 1, 2007,~~ listed in 9VAC25-820-80 will have individual dates for compliance based on their respective compliance plans, that may be earlier than the basin schedule listed in subdivision 1 of this subsection.

b. Facilities listed in 9VAC25-820-70 that ~~have waived~~ waive their compliance schedules in accordance with 9VAC25-820-40 A 2 b shall have an individual compliance date of January 1, ~~2007~~ 2012.

c. Upon completion of the projects contained in their compliance plans, facilities listed in 9VAC25-820-80

may receive a revised individual compliance date of January 1 for the calendar year immediately following the year in which a Certificate to Operate was issued for the capital projects, but not later than the basin schedule listed in subdivision 1 of this subsection.

d. New and expanded facilities will have individual dates for compliance corresponding to the date that coverage under this general permit was extended to the facility.

3. The 39 significant dischargers in the James River Basin shall meet aggregate delivered waste load allocations of 8,163,209 lbs/yr TN and 457,384 lbs/yr TP by January 1, 2023.

D. Annual update of compliance plan. Every owner or operator of a facility required to submit a registration statement shall either individually or through the Virginia Nutrient Credit Exchange Association submit updated compliance plans to the department no later than February 1 of each year. The compliance plans shall contain, at a minimum, any capital projects and implementation schedules needed to achieve total nitrogen and phosphorus reductions sufficient to comply with the individual waste load allocations on the registration list and ~~combined~~ aggregate waste load allocations ~~of all the permittees~~ in ~~the tributary~~ Part I C 3. Compliance plans for facilities that were required to submit a registration statement with the department ~~by January 1, 2007,~~ under Part I G 1 a may rely on the acquisition of point source credits in accordance with Part I J of this general permit, but not the acquisition of credits through payments into the Water Quality Improvement Fund, to achieve compliance with the individual and combined waste load allocations in each tributary. Compliance plans for expansions or new discharges for facilities that are required to submit a registration statement with the department under Part I G 1 b and c may rely on the acquisition of allocation in accordance with Part II B of this general permit to achieve compliance with the individual and combined waste load allocations in each tributary.

E. Monitoring requirements.

1. Discharges shall be monitored by the permittee during weekdays as specified below unless the department determines that weekday only sampling results in a non-representative load. Weekend monitoring and/or alternative monthly load calculations to address production schedules or seasonal flows shall be submitted to the department for review and approval on a case-by-case basis:

Parameter	Sample Type and Collection Frequency			
STP design flow	~~>20.0~~ ≥20.0 MGD	1.0-19.999 MGD	0.040-0.999 MGD	< 0.040 MGD
Effluent TN load limit for industrial facilities		>100,000 lb/yr	487-99,999 lb/yr	< 487 lb/yr
Effluent TP load limit for industrial facilities		>10,000 lb/yr	37-9,999 lb/yr	< 37 lb/yr
~~Parameter~~	~~Sample Type and Collection Frequency~~			
Flow	Totalizing, Indicating and Recording			1/Day, see individual VPDES permit for sample type
Nitrogen Compounds (Total Nitrogen = TKN + NO_2- (as N) + NO_3- (as N))	24 HC 3 Days/Week	24 HC 1/Week	8 HC 2/Month, > 7 days apart	1/Month Grab
Total Phosphorus ~~Compounds (Total Phosphorus and Orthophosphate)~~	24 HC 3 Days/Week	24 HC 1/Week	8 HC 2/Month, > 7 days apart	1/Month Grab

2. Monitoring for compliance with effluent limitations shall be performed in a manner identical to that used to determine compliance with effluent limitations established in the individual VPDES permit ~~and monitoring.~~ Monitoring or sampling shall be conducted according to analytical laboratory methods approved under 40 CFR Part 136 ~~(2006)~~, unless other test or sample collection procedures have been requested by the permittee and approved by the department in writing. All analysis for compliance with effluent limitations shall be in accordance with 1VAC30-45, Certification for Noncommercial Environmental Laboratories, or 1VAC30-46, Accreditation for Commercial Environmental Laboratories. Monitoring may be performed by the permittee at frequencies more stringent than listed above; however, the permittee shall report all results of such monitoring.

3. Loading values greater than or equal to 10 pounds reported in accordance with Part I E and F of this general permit shall be calculated and reported to the nearest pound without regard to mathematical rules of precision. Loading values of less than 10 pounds reported in accordance with Part I E and F of this general permit shall be calculated and reported to at least two significant digits with the exception that all complete calendar year annual loads shall be reported to the nearest pound.

4. Data shall be reported on a form provided by the department, by the same date each month as is required by the facility's individual permit. The total monthly load shall be calculated in accordance with the following formula:

~~$ML = ML_{avg} * d$~~

~~where:~~

~~ML = total monthly load (lb/mo)~~

~~ML_{avg} = monthly average load as reported on DMR (lb/d)~~

~~d = number of discharge days in the calendar month~~

~~$ML_{avg} = \sum DL / s$~~

$$ML = \left(\frac{\sum DL}{s} \right) \times d$$

where:

ML = total monthly load (lb/mo) = average daily load for the calendar month multiplied by the number of days of the calendar month

DL = daily load = daily concentration (expressed as mg/l to the nearest 0.01 mg/l) multiplied by the flow volume of effluent discharged during the 24-hour period (expressed as MGD to at least the nearest 0.01 ~~MGD)~~ MGD and in no case less than two significant digits), multiplied by ~~8.3438 and~~ 8.345. Daily loads greater than or equal to 10 pounds may be rounded to the nearest whole number to convert to pounds per day (lbs/day). Daily loads less than or equal to 10 pounds may be rounded to no fewer than two significant fiqures.

s = number of days in the calendar month in which a sample was collected and analyzed

d = number of discharge days in the calendar month

~~All~~ For total phosphorus, all daily concentration data below the quantification level (QL) for the analytical method used should be treated as half the QL. All daily concentration data equal to or above the QL for the analytical method used shall be treated as it is reported. If all data are below the QL, then the average shall be reported as half the QL.

For total nitrogen (TN), if none of the daily concentration data for the respective species (i.e., TKN, nitrates/nitrites) are equal to or above the QL for the respective analytical methods used, the daily TN concentration value reported shall equal one half of the largest QL used for the respective species. If one of the data is equal to or above the QL, the daily TN concentration value shall be treated as that data point as reported. If more than one of the data is above the QL, the daily TN concentration value shall equal the sum of the data points as reported.

The total year-to-date mass load shall be calculated in accordance with the following formula:

~~AL-YTD = $\sum_{(Jan-currentmonth)} ML$~~

$$AL_{YTD} = \sum_{(Jan-present)} ML$$

where:

AL-YTD = calendar year-to-date annual load (lb/yr)

ML = total monthly load (lb/mo) ~~as reported on DMR~~

F. Annual reporting.

1. Annually, on or before February 1, the permittee shall either individually or through the Virginia Nutrient Credit Exchange Association file a report with the department, using a reporting form supplied by the department. The report shall identify:

a. The annual mass load of total nitrogen and the annual mass load of total phosphorus discharged by each of its permitted facilities during the previous calendar year;

b. The delivered total nitrogen load and delivered total phosphorus load discharged by each of its permitted facilities during the previous year; and

c. The number of total nitrogen and total phosphorus credits for the previous calendar year to be acquired or eligible for exchange by the permittee.

The total annual mass load shall be calculated in accordance with the following formula:

~~AL = $\sum_{(Jan-Dec)} ML$~~

$$AL = \sum_{(Jan-Dec)} ML$$

where:

AL = calendar year annual load (lb/yr)

ML = total monthly load (lb/mo) ~~as reported on DMR~~

G. Requirement to register; exclusions.

1. The following owners or operators are required to register for coverage under this general permit:

a. Every owner or operator of an existing facility authorized by a Virginia Pollutant Discharge Elimination System permit to discharge 100,000 gallons or more per day from a sewage treatment work, or an equivalent load from an industrial facility, directly into tidal waters, or 500,000 gallons or more per day from a sewage treatment work, or an equivalent load from an industrial facility, directly into nontidal waters, shall submit a registration statement to the department by ~~January 1, 2007~~ November 1, 2011, and thereafter upon the reissuance of this general permit in accordance with Part III B. The conditions of this general permit will apply to such owner and operator upon approval of a registration statement.

b. Any owner or operator of a facility authorized by a Virginia Pollutant Discharge Elimination System permit to discharge 40,000 gallons or more per day from a sewage treatment work, or an equivalent load from an industrial facility, directly into tidal or nontidal waters shall submit a registration statement with the department at the time he makes application for an individual permit with the department for a new discharge or expansion that is subject to an offset requirement in Part II of this general permit or technology-based requirement in ~~Part II of this general permit~~ 9VAC25-40-70, and thereafter upon the reissuance of this general permit in accordance with Part III B. The conditions of this general permit will apply to such owner or operator beginning on the start of the calendar year immediately following ~~submittal~~ approval of a registration statement and issuance or modification of the individual permit.

c. Any owner or operator of a facility treating domestic sewage authorized by a Virginia Pollutant Discharge Elimination System permit with a discharge greater than 1,000 gallons per day up to and including 39,999 gallons per day that has not commenced the discharge of pollutants prior to January 1, 2011, shall submit a registration statement with the department at the time he makes application for an individual permit with the department or prior to commencing a discharge, which ever occurs first, and thereafter upon the reissuance of this general permit in accordance with Part III B.

2. All other categories of discharges are excluded from registration under this general permit.

H. Registration statement.

1. The registration statement shall contain the following information:

a. Name, mailing address and telephone number, e-mail address and fax number of the owner (and facility operator, if different from the owner) applying for permit coverage;

b. Name (or other identifier), address, city or county, contact name, phone number, e-mail address and fax number for the facility for which the registration statement is submitted;

c. VPDES permit numbers for all permits assigned to the facility, or pursuant to which the discharge is authorized;

d. If applying for an aggregated waste load allocation in accordance with Part I B 2 of this permit, list all affected facilities and the VPDES permit numbers assigned to these facilities;

e. For new and expanded facilities, a plan to offset new or increased delivered total nitrogen and delivered total phosphorus loads, including the amount of waste load allocation acquired. Waste load allocations sufficient to offset projected nutrient loads must be provided for period of at least five years; and

f. For existing facilities, the amount of a facility's waste load allocation transferred to or from another facility to offset new or increased delivered total nitrogen and delivered total phosphorus loads from a new discharge or expansion.

2. The registration statement shall be submitted to the DEQ Central Office, Office of Water ~~Permit Programs~~ Permits and Compliance Assistance.

3. An amended registration statement shall be submitted upon the acquisition or transfer of a facility's waste load allocation to offset new or increased delivered total nitrogen and delivered total phosphorus loads from a new discharge or expansion.

I. Public notice for registration statements proposing modifications or incorporations of new waste load allocations or delivery factors.

1. All public notices issued pursuant to a proposed modification or incorporation of a (i) new waste load allocation to offset new or increased delivered total nitrogen and delivered total phosphorus loads from a new discharge or expansion, or (ii) delivery factor, shall be published once a week for two consecutive weeks in a major local newspaper of general circulation serving the locality where the facility is located informing the public that the facility intends to apply for coverage under this general permit. At a minimum, the notice shall include:

a. A statement of the owner or operator's intent to register for coverage under this general permit;

b. A brief description of the facility and its location;

c. The amount of waste load allocation that will be acquired or transferred if applicable;

d. The delivery factor for a new discharge or expansion;

e. A statement that the purpose of the public participation is to acquaint the public with the technical aspects of the facility and how the standards and the requirements of this chapter will be met, to identify issues of concern, to facilitate communication and to establish a dialogue between the owner or operator and persons who may be affected by the facility;

f. An announcement of a 30-day comment period~~, in accordance with 9VAC25-720-50 C, 9VAC25-720-60 C, 9VAC25-720-70 C, 9VAC25-720-110 C, and 9VAC25-720-120 C of the Water Quality Management Planning Regulation,~~ and the name, telephone number, and address of the owner's or operator's representative who can be contacted by the interested persons to answer questions;

g. The name, telephone number, and address of the DEQ representative who can be contacted by the interested persons to answer questions, or where comments shall be sent; and

h. The location where copies of the documentation to be submitted to the department in support of this general permit notification and any supporting documents can be viewed and copied.

2. The owner or operator shall place a copy of the documentation and support documents in a location accessible to the public in the vicinity of the proposed facility.

3. The public shall be provided 30 days to comment on the technical and the regulatory aspects of the proposal. The comment period will begin on the date the notice is published in the local newspaper.

J. Compliance with waste load allocations.

1. Methods of compliance. The permitted facility shall comply with its waste load allocation contained in the registration list maintained by the department. The permitted facility shall be in compliance with its waste load allocation if:

a. The annual mass load is less than or equal to the applicable waste load allocation assigned to the facility in this general permit (or permitted design capacity for expanded facilities without allocations);

b. The permitted facility acquires sufficient point source nitrogen or phosphorus credits in accordance with subdivision 2 of this subsection; provided, however, that the acquisition of nitrogen or phosphorus credits pursuant to this section shall not alter or otherwise affect the individual waste load allocations for each permitted facility; or

c. In the event it is unable to meet the individual waste load allocation pursuant to subdivision 1 a or 1 b of this subsection, the permitted facility acquires sufficient nitrogen or phosphorus credits through payments made into the Water Quality Improvement Fund pursuant to subdivision 3 of this subsection; provided, however, that the acquisition of nitrogen or phosphorus credits pursuant to this section shall not alter or otherwise affect the individual waste load allocations for each permitted facility.

2. Credit acquisition from permitted facilities. A permittee may acquire point source nitrogen credits or point source phosphorus credits from one or more permitted facilities with waste load allocations in 9VAC25-720-50 C, 9VAC25-720-60 C, 9VAC25-720-70 C, 9VAC25-720-110 C and 9VAC25-720-120 C of the Water Quality Management Planning Regulation, including the Blue Plains wastewater treatment facility operated by the District of Columbia Water and Sewer Authority, only if:

a. The credits are generated and applied to a compliance obligation in the same calendar year;

b. The credits are generated by one or more permitted facilities in the same tributary<u>, except that permitted facilities in the Eastern Shore basin may also acquire credits from permitted facilities in the Potomac and Rappahannock tributaries. Eastern shore facilities may acquire credits from the Potomac tributary at a trading ratio of 1:1. A trading ratio of 1.3:1 shall apply to the acquisition of credits from the Rappahannock tributary by an Eastern Shore facility</u>;

c. The exchange or acquisition of credits does not affect any requirement to comply with local water quality-based limitations as determined by the board;

d. The credits are acquired no later than June 1 immediately following the calendar year in which the credits are applied;

e. The credits are generated by a facility that has been constructed, and has discharged from treatment works whose design flow or equivalent industrial activity is the basis for the facility's waste load allocations (until a facility is constructed and has commenced operation, such credits are held, and may be sold, by the Water Quality Improvement Fund; and

f. No later than June 1 immediately following the calendar year in which the credits are applied, the permittee certifies on a credit exchange notification form supplied by the department that he has acquired sufficient credits to satisfy his compliance obligations. The permittee shall comply with the terms and conditions contained in the credit exchange notification form submitted to the department.

3. Credit acquisitions from the Water Quality Improvement Fund. Until such time as the board finds that no allocations

are reasonably available in an individual tributary, permittees that cannot meet their total nitrogen or total phosphorus effluent limit may acquire nitrogen or phosphorus credits through payments made into the Virginia Water Quality Improvement Fund established in § 10.1-2128 of the Code of Virginia only if, no later than June 1 immediately following the calendar year in which the credits are to be applied, the permittee certifies on a form supplied by the department that he has diligently sought, but has been unable to acquire, sufficient credits to satisfy his compliance obligations through the acquisition of point source nitrogen or phosphorus credits with other permitted facilities ~~in the same tributary~~, and that he has acquired sufficient credits to satisfy his compliance obligations through one or more payments made in accordance with the terms of this general permit. Such certification may include, but not be limited to, providing a record of solicitation or demonstration that point source allocations are not available for sale in the tributary in which the permittee is located. Payments to the Water Quality Improvement Fund shall be in the amount of ~~$11.06~~ $6.04 for each pound of nitrogen and ~~$5.04~~ $15.08 for each pound of phosphorus and shall be subject to the following requirements:

a. The credits are generated and applied to a compliance obligation in the same calendar year,

b. The credits are generated in the same tributary, except that permitted facilities in the Eastern Shore basin may also acquire credits from the Potomac and Rappahannock tributaries. Eastern shore facilities may acquire credits from the Potomac tributary at a trading ratio of 1:1. A trading ratio of 1.3:1 shall apply to the acquisition of credits from the Rappahannock tributary by an Eastern Shore facility.

c. The acquisition of credits does not affect any requirement to comply with local water quality-based limitations, as determined by the board.

4. This general permit neither requires, nor prohibits a municipality or regional sewerage authority's development and implementation of trading programs among industrial users, which are consistent with the pretreatment regulatory requirements at 40 CFR Part 403 and the municipality's or authority's individual VPDES permit.

Part II
Special Conditions Applicable To New And Expanded Facilities

A. Offsetting mass loads discharged by new and expanded facilities.

1. An owner or operator of a new or expanded facility shall comply with the applicable requirements of this section as a condition of the facility's coverage under this general permit.

a. An owner or operator of a facility authorized by a Virginia Pollutant Discharge Elimination System permit first issued before July 1, 2005, that expands his facility to discharge 40,000 gallons or more per day, or an equivalent load, shall demonstrate to the department that he has acquired waste load allocations sufficient to offset any increase in his delivered total nitrogen and delivered total phosphorus loads resulting from any expansion beyond his permitted capacity as of July 1, 2005.

b. An owner or operator of a facility authorized by a Virginia Pollutant Discharge Elimination System permit first issued on or after July 1, 2005, to discharge 40,000 gallons or more per day, or an equivalent load, shall demonstrate to the department that he has acquired waste load allocations sufficient to offset his delivered total nitrogen and delivered total phosphorus loads.

c. An owner or operator of a facility treating domestic sewage authorized by a Virginia Pollutant Discharge Elimination System permit with a discharge greater than 1,000 gallons per day up to and including 39,999 gallons per day that has not commenced the discharge of pollutants prior to January 1, 2011, shall demonstrate to the department that he has acquired waste load allocations sufficient to offset his delivered total nitrogen and delivered phosphorus loads prior to commencing the discharge, except when the facility is for short-term temporary use only or when treatment of domestic sewage is not the primary purpose of the facility.

2. Offset calculations shall address the proposed discharge that exceeds:

a. The applicable waste load allocation assigned to the facility in this general permit, for expanding significant dischargers with a ~~wasteload~~ waste load allocation listed in 9VAC25-720-50 C, 9VAC25-720-60 C, 9VAC25-720-70 C, 9VAC25-720-110 C, and 9VAC25-720-120 C of the Water Quality Management Planning Regulation;

b. The permitted design capacity, for all other expanding dischargers; and

c. Zero, for facilities with a new discharge.

3. An owner or operator of multiple facilities located in the same tributary, and assigned an aggregate mass load limit in accordance with Part I B 2 of this general permit, that undertakes construction of new or expanded facilities, shall be required to acquire waste load allocations sufficient to offset any increase in delivered total nitrogen and delivered total phosphorus loads resulting from any expansion beyond the aggregate mass load limit assigned these facilities.

B. Acquisition of waste load allocations. Waste load allocations required by this section to offset new or increased

delivered total nitrogen and delivered total phosphorus loads shall be acquired in accordance with this section.

1. Such allocations may be acquired from one or a combination of the following:

a. Acquisition of all or a portion of the waste load allocations from one or more permitted facilities, based on delivered pounds by the respective trading parties as listed by the department;

b. Acquisition of nonpoint source load allocations, using a trading ratio of two pounds reduced for every pound to be discharged, through the use of best management practices that are:

(1) Acquired through a public or private entity acting on behalf of the land owner;

(2) Calculated using best management practices efficiency rates and attenuation rates, as established by the latest science and relevant technical information, and approved by the board;

(3) Based on appropriate delivery factors, as established by the latest science and relevant technical information, and approved by the board;

(4) Demonstrated to have achieved reductions beyond those already required by or funded under federal or state law, or by the Virginia tributaries strategies plans; ~~and~~

(5) Included as conditions of the facility's individual Virginia Pollutant Discharge Elimination System permit; and

(6) In the case of allocations generated by land use conversions and stormwater retention projects, represent controls beyond those in place as of July 1, 2005 unless the project was specifically designed and approved for use in a stormwater trading program prior to July 1, 2005;

c. Until such time as the board finds that no allocations are reasonably available in an individual tributary, acquisition of allocations through payments made into the Virginia Water Quality Improvement Fund established in § 10.1-2128 of the Code of Virginia; or

d. Acquisition of allocations through such other means as may be approved by the department on a case-by-case basis. This includes allocations granted by the board to an owner or operator of a facility that is authorized by a VPA permit to land apply domestic sewage if:

(1) The VPA permit was issued before July 1, 2005;

(2) The allocation does not exceed the facility's permitted design capacity as of July 1, 2005;

(3) The waste treated by the facility that is covered under the VPA permit will be treated and discharged pursuant to a VPDES permit for a new discharge; and

(4) The owner or operator installs state-of-the-art nutrient removal technology at such a facility.

2. Acquisition of allocations is subject to the following conditions:

a. The allocations shall be generated and applied to an offset obligation in the same calendar year;

b. The allocations shall be generated in the same tributary;

c. Such acquisition does not affect any requirement to comply with local water quality-based limitations, as determined by the board;

d. The allocations are authenticated (i.e., verified to have been generated) by the permittee as required by the facility's individual Virginia Pollutant Discharge Elimination permit, utilizing procedures approved by the board, no later than February 1 immediately following the calendar year in which the allocations are applied; and

e. If obtained from a permitted point source, the allocations shall be generated by a facility that has been constructed, and has discharged from treatment works whose design flow or equivalent industrial activity is the basis for the facility's waste load allocations~~; and~~.

~~f. No later than June 1 in the year prior to the calendar year in which the allocations are to be applied, the permittee shall certify on an exchange notification form supplied by the department that he has acquired sufficient allocations to satisfy his compliance obligations. The permittee shall comply with the terms and conditions contained in the exchange notification form submitted to the department.~~

3. Priority of options. The board shall give priority to allocations acquired in accordance with subdivisions 1 a and 1 b of this subsection. The board shall approve allocations acquired in accordance with subdivisions 1 c and 1 d of this subsection only after the owner or operator has demonstrated that he has made a good faith effort to acquire sufficient allocations in accordance with subdivisions 1 a and 1 b of this subsection, and that such allocations are not reasonably available taking into account timing, cost and other relevant factors. Such demonstration may include, but not be limited to, providing a record of solicitation, or other demonstration that point source allocations or nonpoint source allocations are not available for sale in the tributary in which the permittee is located.

4. Annual allocation acquisitions from the Water Quality Improvement Fund. The cost for each pound of nitrogen

and each pound of phosphorus shall be determined at the time payment is made to the WQIF, based on the higher of (i) the estimated cost of achieving a reduction of one pound of nitrogen or phosphorus at the facility that is securing the allocation, or comparable facility, for each pound of allocation acquired; or (ii) the average cost, as determined by the Department of Conservation and Recreation on an annual basis, of reducing two pounds of nitrogen or phosphorus from nonpoint sources in the same tributary for each pound of allocation acquired.

Part III
Conditions Applicable To All VPDES Permits

A. Duty to comply. The permittee must comply with all conditions of the permit. Any permit noncompliance constitutes a violation of the law and the Clean Water Act, except that noncompliance with certain provisions of the permit may constitute a violation of the law but not the Clean Water Act. Permit noncompliance is grounds for enforcement action; for permit termination, revocation and reissuance, or modification; or denial of a permit renewal application.

B. Duty to register for reissued general permit. If the permittee wishes to continue an activity regulated by the general permit after its expiration date, the permittee must register for coverage under the new general permit, when it is reissued by the department.

C. Need to halt or reduce activity not a defense. It shall not be a defense for a permittee in an enforcement action that it would have been necessary to halt or reduce the permitted activity in order to maintain compliance with the conditions of the permit.

D. Duty to mitigate. The permittee shall take all reasonable steps to minimize or prevent any discharge in violation of the permit that has a reasonable likelihood of adversely affecting human health or the environment.

E. Proper operation and maintenance. The permittee shall at all times properly operate and maintain all facilities and systems of treatment and control (and related appurtenances) that are installed or used by the permittee to achieve compliance with the conditions of the permit. Proper operation and maintenance also includes adequate laboratory controls and appropriate quality assurance procedures. This provision requires the operation of back-up or auxiliary facilities or similar systems that are installed by a permittee only when the operation is necessary to achieve compliance with the conditions of the permit.

F. Permit actions. Permits may be modified, revoked and reissued, or terminated for cause. The filing of a request by the permittee for a permit modification, revocation and reissuance, or termination, or a notification of planned changes or anticipated noncompliance does not stay any permit condition.

G. Property rights. Permits do not convey any property rights of any sort, or any exclusive privilege.

H. Duty to provide information. The permittee shall furnish to the department, within a reasonable time, any information that the board may request to determine whether cause exists for modifying, revoking and reissuing, or terminating the permit or to determine compliance with the permit. The board may require the permittee to furnish, upon request, such plans, specifications, and other pertinent information as may be necessary to determine the effect of the wastes from his discharge on the quality of state waters, or such other information as may be necessary to accomplish the purposes of the law. The permittee shall also furnish to the department upon request, copies of records required to be kept by the permit, pertaining to activities related to the permitted facility.

I. Inspection and entry. The permittee shall allow the director, or an authorized representative (including an authorized contractor acting as a representative of the administrator), upon presentation of credentials and other documents as may be required by law, to:

1. Enter upon the permittee's premises where a regulated facility or activity is located or conducted, or where records must be kept under the conditions of the permit;

2. Have access to and copy, at reasonable times, any records that must be kept under the conditions of the permit;

3. Inspect at reasonable times any facilities, equipment (including monitoring and control equipment), practices, or operations regulated or required under the permit; and

4. Sample or monitor at reasonable times, for the purposes of assuring permit compliance or as otherwise authorized by the Clean Water Act and the law, any substances or parameters at any location.

J. Monitoring and records.

1. Samples and measurements taken for the purpose of monitoring shall be representative of the monitored activity.

2. The permittee shall retain records of all monitoring information, including all calibration and maintenance records and all original strip chart recordings for continuous monitoring instrumentation, copies of all reports required by the permit, and records of all data used to complete the application for the permit, for a period of at least three years from the date of the sample, measurement, report or application. This period of retention shall be extended automatically during the course of any unresolved litigation regarding the regulated activity or regarding control standards applicable to the permittee, or as requested by the board.

3. Records of monitoring information shall include:

a. The date, exact place, and time of sampling or measurements;

b. The individual(s) who performed the sampling or measurements;

c. The date(s) analyses were performed;

d. The individual(s) who performed the analyses;

e. The analytical techniques or methods used; and

f. The results of such analyses.

4. Monitoring results must be conducted according to test procedures approved under 40 CFR Part 136 (2006) or alternative EPA-approved methods, unless other test procedures have been specified in the permit.

K. Signatory requirements. All applications, reports, or information submitted to the department shall be signed and certified as required by 9VAC25-31-110.

L. Reporting requirements.

1. The permittee shall give notice to the department as soon as possible of any planned physical alterations or additions to the permitted facility. Notice is required only when:

a. The alteration or addition to a permitted facility may meet one of the criteria for determining whether a facility is a new source in 9VAC25-31-180 A; or

b. The alteration or addition could significantly change the nature or increase the quantity of pollutants discharged. This notification applies to pollutants that are subject neither to effluent limitations in the permit, nor to notification requirements under 9VAC25-31-200 A 1.

2. The permittee shall give advance notice to the department of any planned changes in the permitted facility or activity that may result in noncompliance with permit requirements.

3. Permits are not transferable to any person except after notice to the department. The board may require modification or revocation and reissuance of permits to change the name of the permittee and incorporate such other requirements as may be necessary under the law or the Clean Water Act.

4. Monitoring results shall be reported at the intervals specified in the permit.

a. Monitoring results must be reported on a Discharge Monitoring Report (DMR).

b. If the permittee monitors any pollutant specifically addressed by the permit more frequently than required by the permit using test procedures approved under 40 CFR Part 136 (2006), or as specified in the permit, the results of this monitoring shall be included in the calculation and reporting of the data submitted in the DMR specified by the department.

c. Calculations for all limitations that require averaging of measurements shall utilize an arithmetic mean unless otherwise specified in the permit.

5. Reports of compliance or noncompliance with, or any progress reports on, interim and final requirements contained in any compliance schedule of the permit shall be submitted no later than 14 days following each schedule date.

6. If any unusual or extraordinary discharge including a bypass or upset should occur from a facility and such discharge enters or could be expected to enter state waters, the owner shall promptly notify, in no case later than 24 hours, the department by telephone after the discovery of such discharge. This notification shall provide all available details of the incident, including any adverse affects on aquatic life and the known number of fish killed. The permittee shall reduce the report to writing and shall submit it to the department within five days of discovery of the discharge in accordance with subdivision 7 a of this subsection. Unusual and extraordinary discharges include but are not limited to any discharge resulting from:

a. Unusual spillage of materials resulting directly or indirectly from processing operations;

b. Breakdown of processing or accessory equipment;

c. Failure or taking out of service of the treatment work or auxiliary facilities (such as sewer lines or wastewater pump stations); and

d. Flooding or other acts of nature.

7. Twenty-four-hour reporting.

a. The permittee shall report any noncompliance that may endanger health or the environment. Any information shall be provided orally within 24 hours from the time the permittee becomes aware of the circumstances. A written submission shall also be provided within five days of the time the permittee becomes aware of the circumstances. The written submission shall contain a description of the noncompliance and its cause; the period of noncompliance, including exact dates and times, and if the noncompliance has not been corrected, the anticipated time it is expected to continue; and steps taken or planned to reduce, eliminate, and prevent reoccurrence of the noncompliance.

b. The following shall be included as information that must be reported within 24 hours under this subdivision.

(1) Any unanticipated bypass that exceeds any effluent limitation in the permit.

(2) Any upset that exceeds any effluent limitation in the permit.

(3) Violation of a maximum daily discharge limitation for any of the pollutants listed in the permit to be reported within 24 hours.

c. The board may waive the written report on a case-by-case basis for reports under this subdivision if the oral report has been received within 24 hours.

8. The permittee shall report all instances of noncompliance not reported under subdivisions 4, 5, 6, and 7 of this subsection, in writing at the time the next monitoring reports are submitted. The reports shall contain the information listed in subdivision 7 of this subsection.

9. Where the permittee becomes aware that it failed to submit any relevant facts in a permit application, or submitted incorrect information in a permit application or in any report to the department, it shall promptly submit such facts or information.

M. Bypass.

1. The permittee may allow any bypass to occur that does not cause effluent limitations to be exceeded, but only if it also is for essential maintenance to assure efficient operation. These bypasses are not subject to the provisions of subdivisions 2 and 3 of this subsection.

2. Notice.

a. Anticipated bypass. If the permittee knows in advance of the need for a bypass, it shall submit prior notice, if possible at least 10 days before the date of the bypass.

b. Unanticipated bypass. The permittee shall submit notice of an unanticipated bypass as required in subdivision L 7 of this section (24-hour notice).

3. Prohibition of bypass.

a. Bypass is prohibited, and the board may take enforcement action against a permittee for bypass, unless:

(1) Bypass was unavoidable to prevent loss of life, personal injury, or severe property damage;

(2) There were no feasible alternatives to the bypass, such as the use of auxiliary treatment facilities, retention of untreated wastes, or maintenance during normal periods of equipment downtime. This condition is not satisfied if adequate back-up equipment should have been installed in the exercise of reasonable engineering judgment to prevent a bypass that occurred during normal periods of equipment downtime or preventive maintenance; and

(3) The permittee submitted notices as required under subdivision 2 of this subsection.

b. The board may approve an anticipated bypass, after considering its adverse effects, if the board determines that it will meet the three conditions listed above in subdivision 3 a of this subsection.

N. Upset.

1. An upset constitutes an affirmative defense to an action brought for noncompliance with such technology-based permit effluent limitations if the requirements of subdivision 2 of this subsection are met. No determination made during administrative review of claims that noncompliance was caused by upset, and before an action for noncompliance, is final administrative action subject to judicial review.

2. A permittee who wishes to establish the affirmative defense of upset shall demonstrate, through properly signed, contemporaneous operating logs, or other relevant evidence that:

a. An upset occurred and that the permittee can identify the cause(s) of the upset;

b. The permitted facility was at the time being properly operated;

c. The permittee submitted notice of the upset as required in subdivision L 7 b (2) of this section (24-hour notice); and

d. The permittee complied with any remedial measures required under subsection D of this section.

3. In any enforcement proceeding, the permittee seeking to establish the occurrence of an upset has the burden of proof.

9VAC25-820-80. Facilities subject to reduced individual total nitrogen and total phosphorus waste load allocations.

The facilities identified in this section are subject to reduced individual total nitrogen and total phosphorus waste load allocations as indicated.

Facility	Registration No.	Basin	Parameter
Caroline Co. Regional STP	VAN030045	York	TP
Gordonsville STP	VAN030046	York	TP
Hanover County Aggregate	VAN030051	York	TP
White Birch Paper - Bear Island LLC Division	VAN030133	York	TP
Western Refinery - Yorktown	VAN030047	York	TP

HRSD York River Aggregate	VAN030052	York	TP
Parham Landing WWTP	VAN030048	York	TP
Smurfit Stone	VAN030049	York	TP
HRSD James River Aggregate	VAN040090	James	TN

VA.R. Doc. No. R10-2123; Filed May 4, 2011, 10:05 a.m.

TITLE 10. FINANCE AND FINANCIAL INSTITUTIONS

STATE CORPORATION COMMISSION

Proposed Regulation

REGISTRAR'S NOTICE: The State Corporation Commission is exempt from the Administrative Process Act in accordance with § 2.2-4002 A 2 of the Code of Virginia, which exempts courts, any agency of the Supreme Court, and any agency that by the Constitution is expressly granted any of the powers of a court of record.

Title of Regulation: **10VAC5-210. Motor Vehicle Title Lending (amending 10VAC5-210-30, 10VAC5-210-50, 10VAC5-210-60, 10VAC5-210-90; adding 10VAC5-210-95).**

Statutory Authority: §§ 6.2-2214 and 12.1-13 of the Code of Virginia.

Public Hearing Information: A public hearing will be held upon request.

Public Comment Deadline: June 6, 2011.

Agency Contact: Gerald Fallen, Deputy Commissoner, Bureau of Financial Institutions, State Corporation Commission, P.O. Box 640, Richmond, VA 23218, telephone (804) 371-9699, FAX (804) 371-9416, or email gerald.fallen@scc.virginia.gov.

Summary:

The State Corporation Commission is proposing changes to 10VAC5-210, which apply to motor vehicle title lenders licensed under Chapter 22 (§ 6.2-2200 et seq.) of Title 6.2 of the Code of Virginia. Effective July 1, 2011, Chapter 418 of the 2011 Acts of Assembly eliminates various provisions in Chapter 22 that currently prohibit motor vehicle title lenders from making loans secured by motor vehicles registered outside of Virginia. Accordingly, the commission is proposing conforming amendments. The commission is also proposing a regulation prescribing the annual fees to be paid by motor vehicle title lenders licensed under Chapter 22 that will defray the costs of the examination, supervision, and regulation of licensees. Lastly, the commission is proposing to add clarification regarding motor vehicle title loans that have been arranged or brokered by another person. The proposed regulations have a proposed effective date of July 1, 2011, to coincide with the effective date of Chapter 418.

AT RICHMOND, APRIL 29, 2011

COMMONWEALTH OF VIRGINIA, ex rel.

STATE CORPORATION COMMISSION

CASE NO. BFI-2011-00025

Ex Parte: In re: amendments to
motor vehicle title lending regulations

ORDER TO TAKE NOTICE

Section 6.2-2214 of the Code of Virginia provides that the State Corporation Commission ("Commission") shall adopt such regulations as it deems appropriate to effect the purposes of Chapter 22 (§ 6.2-2200 et seq.) of Title 6.2 of the Code of Virginia ("Chapter 22"). The Commission's motor vehicle title lending regulations are set forth in Title 10 of the Virginia Administrative Code.

The Bureau of Financial Institutions ("Bureau") has submitted to the Commission proposed amendments to 10 VAC 5-210-10 et seq. of the Virginia Administrative Code ("Chapter 210"). The primary impetus for the proposed amendments is Chapter 418 of the 2011 Virginia Acts of Assembly ("Chapter 418"), which becomes effective on July 1, 2011. Chapter 418 amends Chapter 22 by eliminating provisions that currently prohibit motor vehicle title lenders from making loans secured by motor vehicles that are registered outside of Virginia.

The Bureau is also proposing to add a new section to Chapter 210 based on § 6.2-2213 of the Code of Virginia, which requires licensed motor vehicle title lenders to pay an annual fee calculated in accordance with a schedule set by the Commission. The annual fee will defray the costs of the examination, supervision, and regulation of licensees under Chapter 22. The schedule is required to bear a reasonable relationship to the business volume of such licensees, the actual costs of their examinations, and other factors relating to their supervision and regulation.

Lastly, the Bureau is proposing to add a clarification to 10 VAC 5-210-50 regarding motor vehicle title loans that have been arranged or brokered by another person.

NOW THE COMMISSION, based on the information supplied by the Bureau, is of the opinion and finds that the proposed regulations should be considered for adoption with a proposed effective date of July 1, 2011, in order to coincide with the effective date of Chapter 418.

Accordingly, IT IS ORDERED THAT:

(1) The proposed regulations are appended hereto and made a part of the record herein.

(2) Comments or requests for a hearing on the proposed regulations must be submitted in writing to Joel H. Peck, Clerk, State Corporation Commission, c/o Document Control Center, P.O. Box 2118, Richmond, Virginia 23218, on or before June 6, 2011. Requests for a hearing shall state why a hearing is necessary and why the issues cannot be adequately addressed in written comments. All correspondence shall contain a reference to Case No. BFI-2011-00025. Interested persons desiring to submit comments or request a hearing electronically may do so by following the instructions available at the Commission's website: http://www.scc.virginia.gov/case.

(3) This Order and the attached proposed regulations shall be posted on the Commission's website at http://www.scc.virginia.gov/case.

(4) The Commission's Division of Information Resources shall send a copy of this Order, including a copy of the attached proposed regulations, to the Virginia Registrar of Regulations for publication in the Virginia Register of Regulations.

AN ATTESTED COPY hereof, together with a copy of the proposed regulations, shall be sent by the Clerk of the Commission to the Commission's Office of General Counsel and the Commissioner of Financial Institutions, who shall send a copy of this Order, together with a copy of the proposed regulations, to all licensed motor vehicle title lenders and other interested parties designated by the Bureau.

10VAC5-210-30. Notice and pamphlet.

A. Prior to furnishing a prospective borrower with a loan application or receiving any information relating to loan qualification, a licensee shall provide the prospective borrower with (i) a written notice that complies with subsection B of this section; and (ii) a borrower rights and responsibilities pamphlet that complies with subsections C and D of this section.

B. 1. The required text of the written notice shall be as follows: "WARNING: A motor vehicle title loan is not intended to meet your long-term financial needs. The interest rate on a motor vehicle title loan is high and you are pledging your motor vehicle as collateral for the loan. If you fail to repay your loan in accordance with your loan agreement, we may repossess and sell your motor vehicle. You should consider whether there are other lower cost loans available to you. If you obtain a motor vehicle title loan, you should request the minimum loan amount required to meet your immediate needs." A licensee shall not modify or supplement the required text of the written notice.

2. The written notice shall be printed on a single 8-1/2 x 11 sheet of paper and be separate from all other papers, documents, or notices obtained or furnished by the licensee. The notice shall be printed in at least 24-point bold type and contain an acknowledgment that is signed and dated by each prospective borrower. The acknowledgement shall state the following: "I acknowledge that I have received a copy of this notice and the pamphlet entitled "Motor Vehicle Title Lending in the Commonwealth of Virginia - Borrower Rights and Responsibilities."

3. A duplicate original of the acknowledged notice shall be kept by a licensee in the separate file maintained with respect to the loan for the period specified in § 6.2-2209 of the Code of Virginia.

C. The borrower rights and responsibilities pamphlet shall be printed in at least 12-point type and be separate from all other papers, documents, or notices obtained or furnished by the licensee. The pamphlet shall contain the exact language prescribed in subsection D of this section. A licensee shall not modify or supplement the required text of the pamphlet. The title of the pamphlet ("Motor Vehicle Title Lending in the Commonwealth of Virginia - Borrower Rights and Responsibilities") and the headings for the individual sections of the pamphlet (e.g., "In General," "Notice from Lender," etc.) shall be printed in bold type.

D. The required text of the borrower rights and responsibilities pamphlet shall be as follows:

MOTOR VEHICLE TITLE LENDING IN THE COMMONWEALTH OF VIRGINIA

BORROWER RIGHTS AND RESPONSIBILITIES

Please take the time to carefully review the information contained in this pamphlet. It is designed to advise you of your rights and responsibilities in connection with obtaining a motor vehicle title loan in Virginia under Chapter 22 (§ 6.2-2200 et seq.) of Title 6.2 of the Code of Virginia.

If you have any questions about motor vehicle title lending or want additional information, you may contact the Virginia State Corporation Commission's Bureau of Financial Institutions toll-free at (800) 552-7945 or on the Internet at http://www.scc.virginia.gov/bfi.

In General: You are responsible for evaluating whether a motor vehicle title loan is right for you. Alternatives may include among other things less expensive short-term financing from another financial institution, family, or friends, a cash advance on a credit card, or an account with overdraft protection.

Notice from Lender: A motor vehicle title lender is required to provide you with a clear and conspicuous printed notice advising you that a motor vehicle title loan is not intended to meet your long-term financial needs; that the

interest rate on a motor vehicle title loan is high; and that if you fail to repay your loan in accordance with your loan agreement, the motor vehicle title lender may repossess and sell your motor vehicle.

Prohibition on Obtaining Loan if Motor Vehicle has Existing Lien / One Loan at a Time: Virginia law prohibits a motor vehicle title lender from making a motor vehicle title loan to you if (i) your certificate of title indicates that your motor vehicle is security for another loan or has an existing lien; or (ii) you currently have another motor vehicle title loan from either the same motor vehicle title lender or any other motor vehicle title lender conducting a motor vehicle title lending business in Virginia.

Prohibition on Obtaining Loan on Same Day Another Loan was Repaid: Virginia law prohibits a motor vehicle title lender from making a motor vehicle title loan to you on the same day that you repaid or satisfied in full a motor vehicle title loan from either the same motor vehicle title lender or any other motor vehicle title lender conducting a motor vehicle title lending business in Virginia.

Prohibition on Loans to Covered Members of the Armed Forces and their Dependents: Virginia law prohibits a motor vehicle title lender from making motor vehicle title loans to covered members of the armed forces and their dependents. If you are (i) on active duty under a call or order that does not specify a period of 30 days or less; or (ii) on active guard and reserve duty, then you are a covered member of the armed forces and a motor vehicle title lender is prohibited from making a motor vehicle title loan to you. A motor vehicle title lender is also prohibited from making a motor vehicle title loan to you if (i) you are married to a covered member of the armed forces; (ii) you are the child, as defined in 38 USC § 101(4), of a covered member of the armed forces; or (iii) more than one-half of your support during the past 180 days was provided by a covered member of the armed forces.

Certificate of Title / Other Security Interests: Prior to obtaining a motor vehicle title loan, you will be required to give a motor vehicle title lender the certificate of title for your motor vehicle. The motor vehicle title lender is required to record its lien with the ~~Virginia Department of Motor Vehicles~~ motor vehicle department in the state where your motor vehicle is registered and hold the certificate of title until your loan is repaid or satisfied in full. The motor vehicle title lender cannot take an interest in more than one motor vehicle as security for a motor vehicle title loan. Apart from your motor vehicle and any accessories that are attached to it, the motor vehicle title lender cannot take an interest in any other property you own as security for a motor vehicle title loan.

Maximum Loan Amount: A motor vehicle title lender cannot loan you more than 50% of the fair market value of your motor vehicle. The fair market value is generally based on the loan value for your motor vehicle according to a recognized pricing guide.

Minimum and Maximum Loan Term / Monthly Payments: Under Virginia law, your loan term cannot be either less than 120 days or more than 12 months. Your motor vehicle title loan will be repayable in substantially equal monthly installments of principal and interest. However, if you have a longer first payment period, your first monthly payment may be larger than your remaining monthly payments.

Interest and Other Loan Costs: The following are the maximum interest rates that a motor vehicle title lender is permitted to charge you PER MONTH on the principal amount of your loan that remains outstanding: (i) 22% per month on the portion of the outstanding balance up to and including $700; (ii) 18% per month on the portion of the outstanding balance between ~~$701~~ $700.01 and $1,400; and (iii) 15% per month on the portion of the outstanding balance of ~~$1,401~~ $1,400.01 and higher. As long as these maximum rates are not exceeded, a motor vehicle title lender is allowed to accrue interest using a single blended interest rate if the initial principal is higher than $700. In addition to interest, a motor vehicle title lender may charge you for the actual cost of recording its lien with the ~~Virginia Department of Motor Vehicles~~ motor vehicle department in the state where your motor vehicle is registered.

If you make a payment more than seven calendar days after its due date, a motor vehicle title lender may impose a late charge of up to five percent of the amount of the payment.

A motor vehicle title lender is prohibited from accruing or charging you interest on or after (i) the date the motor vehicle title lender repossesses your motor vehicle; or (ii) 60 days after you fail to make a monthly payment on your loan, unless you are hiding your motor vehicle.

Other than interest and the costs specifically mentioned in this section and the section below ("Costs of Repossession and Sale"), no additional amounts may be directly or indirectly charged, contracted for, collected, received, or recovered by a motor vehicle title lender.

Costs of Repossession and Sale: A motor vehicle title lender may charge you for any reasonable costs that it incurs in repossessing, preparing for sale, and selling your motor vehicle if (i) you default on your motor vehicle title loan; (ii) the motor vehicle title lender sends you a written notice at least 10 days prior to repossession advising you that your motor vehicle title loan is in default and that your motor vehicle may be repossessed unless you pay the outstanding principal and interest; and (iii) you fail to pay the amount owed prior to the date of repossession. A motor vehicle title lender is prohibited from charging you for any storage costs if the motor vehicle title lender takes possession of your motor vehicle.

Written Loan Agreement: A motor vehicle title lender must provide you with a written loan agreement, which must be signed by both you and an authorized representative of the motor vehicle title lender. Your motor vehicle title loan agreement is a binding, legal document that requires you to repay your loan. Make sure you read the entire loan agreement carefully before signing and dating it. A motor vehicle title lender must provide you with a duplicate original of your loan agreement at the time you sign it. If any provision of your loan agreement violates Chapter 22 (§ 6.2-2200 et seq.) of Title 6.2 of the Code of Virginia, the provision will not be enforceable against you.

Property Insurance: A motor vehicle title lender may require you to purchase or maintain property insurance for your motor vehicle. However, a motor vehicle title lender cannot require you to purchase or maintain property insurance from or through a particular provider or list of providers.

Prohibition on Obtaining Funds Electronically: A motor vehicle title lender is prohibited from electronically debiting your deposit account or obtaining any of your funds by electronic means.

Loan Proceeds: You will receive your loan proceeds in the form of (i) cash; (ii) a check from the motor vehicle title lender; or (iii) a debit card. If you receive a check, the motor vehicle title lender is prohibited from charging you a fee for cashing the check. Similarly, a check casher located in the same office as the motor vehicle title lender is prohibited from charging you a fee for cashing the motor vehicle title lender's check. If you receive a debit card, the motor vehicle title lender is prohibited from charging you an additional fee when you withdraw or use the loan proceeds.

Other Businesses: A motor vehicle title lender is prohibited from engaging in any other businesses in its motor vehicle title loan offices unless permitted by order of the State Corporation Commission. A motor vehicle title lender is also prohibited by statute from selling you any type of insurance coverage.

Using Motor Vehicle Title Loan to Purchase Products or Services or Repay Other Loans: A motor vehicle title lender is prohibited from making you a motor vehicle title loan so that you can purchase another product or service sold at the motor vehicle title lender's business location. A motor vehicle title lender is also prohibited from making you a motor vehicle title loan so that you can repay another loan you may have from either the motor vehicle title lender or an affiliate of the motor vehicle title lender.

Right to Cancel: You have the right to cancel your motor vehicle title loan at any time prior to the close of business on the next day the motor vehicle title lender is open following the date your loan is made by either returning the original loan proceeds check or paying the motor vehicle title lender the amount advanced to you in cash or by certified check, cashier's check, money order or, if the motor vehicle title lender is equipped to handle and willing to accept such payments, by using a credit card. If you cancel your motor vehicle title loan, the motor vehicle title lender must mark your original loan agreement with the word "canceled" and return it to you along with your certificate of title.

Cash Payments / Partial Payments / Prepayments: You have the right to receive a signed, dated receipt for each cash payment made in person, which will show the balance remaining on your motor vehicle title loan.

Additionally, you have the right to make a partial payment on your motor vehicle title loan at any time prior to its specified due date without penalty. However, a motor vehicle title lender may apply a partial payment first to any amounts that are due and unpaid at the time of such payment. If your motor vehicle title loan is current, a partial payment will reduce your outstanding balance as well as the total amount of interest that you will be required to pay.

You also have the right to prepay your motor vehicle title loan in full before its specified maturity date without penalty by paying the motor vehicle title lender the total outstanding balance on your loan, including any accrued and unpaid interest and other charges that you may owe on your motor vehicle title loan.

Lender to Return Original Loan Agreement and Certificate of Title: Within 10 days after the date that you repay your motor vehicle title loan in full, the motor vehicle title lender must (i) mark your original loan agreement with the word "paid" or "canceled" and return it to you; (ii) take any action necessary to reflect the termination of its lien on your motor vehicle's certificate of title; and (iii) return the certificate of title to you. If you have any questions or concerns regarding your certificate of title, you should contact the ~~Virginia Department of Motor Vehicles~~ motor vehicle department in the state where your motor vehicle is registered.

No Rollovers, Extensions, Etc.: A motor vehicle title lender cannot refinance, renew, extend, or rollover your motor vehicle title loan.

Failure to Repay: Pay back your motor vehicle title loan! Know when your payments are due and be sure to repay your motor vehicle title loan on time and in full. IF YOU DO NOT REPAY YOUR MOTOR VEHICLE TITLE LOAN IN ACCORDANCE WITH YOUR LOAN AGREEMENT, THE MOTOR VEHICLE TITLE LENDER MAY REPOSSESS AND SELL YOUR MOTOR VEHICLE (see section below on "Repossession and Sale of your Motor Vehicle").

In general, a motor vehicle title lender cannot seek a personal money judgment against you if you fail to pay any amount owed in accordance with your loan agreement. However, a motor vehicle title lender may seek a personal money judgment against you if you impair the motor vehicle

title lender's security interest by (i) intentionally damaging or destroying your motor vehicle; (ii) intentionally hiding your motor vehicle; (iii) giving the motor vehicle title lender a lien on a motor vehicle that has an undisclosed prior lien; (iv) selling your motor vehicle without the motor vehicle title lender's written consent; or (v) securing another loan or obligation with a security interest in your motor vehicle without the motor vehicle title lender's written consent.

In collecting or attempting to collect a motor vehicle title loan, a motor vehicle title lender is required to comply with the restrictions and prohibitions applicable to debt collectors contained in the Fair Debt Collection Practices Act, 15 USC § 1692 et seq., regarding harassment or abuse; false, misleading or deceptive statements or representations; and unfair practices in collections. A motor vehicle title lender is also prohibited from threatening or beginning criminal proceedings against you if you fail to pay any amount owed in accordance with your loan agreement.

Repossession and Sale of your Motor Vehicle: If you do not repay your motor vehicle title loan in accordance with your loan agreement, the motor vehicle title lender may repossess and sell your motor vehicle in order to recover any outstanding amounts that you owe.

If a motor vehicle title lender repossesses your motor vehicle, the motor vehicle title lender must send you a written notice at least 15 days prior to the sale of your motor vehicle. The notice will contain (i) the date and time after which your motor vehicle may be sold; and (ii) a written accounting of the outstanding balance on your motor vehicle title loan, the amount of interest accrued through the date the motor vehicle title lender took possession of your motor vehicle, and any reasonable costs incurred to date by the motor vehicle title lender in connection with repossessing, preparing for sale, and selling your motor vehicle. At any time prior to the sale of your motor vehicle, you may obtain your motor vehicle by paying the motor vehicle title lender the total amount specified in the notice. Payment must be made in cash or by certified check, cashier's check, money order or, if the motor vehicle title lender is equipped to handle and willing to accept such payments, by using a credit card.

Within 30 days of a motor vehicle title lender receiving funds from the sale of your motor vehicle, you are entitled to receive any surplus from the sale in excess of the sum of the following: (i) the outstanding balance on your motor vehicle title loan; (ii) the amount of interest accrued on your motor vehicle title loan through the date the motor vehicle title lender repossessed your motor vehicle; and (iii) any reasonable costs incurred by the motor vehicle title lender in repossessing, preparing for sale, and selling your motor vehicle.

See section above on "Costs of Repossession and Sale" for additional information regarding the conditions that must be met in order for a motor vehicle title lender to collect the reasonable costs of repossessing, preparing for sale, and selling your motor vehicle.

Violation of the Virginia Consumer Protection Act: Losses suffered as the result of a motor vehicle title lender's violation of Chapter 22 (§ 6.2-2200 et seq.) of Title 6.2 of the Code of Virginia may be pursued under the Virginia Consumer Protection Act (§ 59.1-196 et seq. of the Code of Virginia), which in some cases permits consumers to recover actual and punitive damages.

Complaints and Contacting the Bureau of Financial Institutions: For assistance with any complaints you may have against a motor vehicle title lender, please contact the Bureau of Financial Institutions toll-free at (800) 552-7945 or on the Internet at http://www.scc.virginia.gov/bfi. Complaints must be filed in writing with the Bureau of Financial Institutions. Complaints should be mailed to the Bureau of Financial Institutions, Attn: Complaints, P.O. Box 640, Richmond, Virginia 23218-0640, or faxed to the Bureau of Financial Institutions, Attn: Complaints, at (804) 371-9416.

10VAC5-210-50. Additional business requirements and restrictions.

A. Each original license shall be prominently posted in each place of business of the licensee.

B. A licensee shall post in or on its licensed locations the days and hours during which it is open for business so that the posting is legible from outside.

C. A licensee shall endeavor to provide the loan documents, printed notice, and pamphlet required by 10VAC5-210-30, in a language other than English when a prospective borrower is unable to read the materials printed in English.

D. A licensee shall not knowingly make a motor vehicle title loan to (i) a person who has an outstanding motor vehicle title loan from the same licensee or another licensee; (ii) a covered member of the armed forces; or (iii) a dependent of a covered member of the armed forces. To enable a licensee to make these determinations and the determination in subsection F of this section, a licensee shall clearly and conspicuously include the following questions in its written loan application, which the licensee shall require each applicant to answer before obtaining a motor vehicle title loan. A licensee shall not make a motor vehicle title loan to an applicant unless the applicant answers "no" to all of these questions:

1. Do you currently have a motor vehicle title loan from any motor vehicle title lender?

2. At any time today, did you repay or satisfy in full a motor vehicle title loan from any motor vehicle title lender?

3. Are you (i) on active duty in the armed forces under a call or order that does not specify a period of 30 days or less, or (ii) on active guard and reserve duty?

4. Are you married to an individual who is either (i) on active duty in the armed forces under a call or order that does not specify a period of 30 days or less, or (ii) on active guard and reserve duty?

5. Are you the child, as defined in 38 USC § 101(4), of an individual who is either (i) on active duty in the armed forces under a call or order that does not specify a period of 30 days or less, or (ii) on active guard and reserve duty?

6. Was more than one-half of your support during the past 180 days provided by an individual who is either (i) on active duty in the armed forces under a call or order that does not specify a period of 30 days or less, or (ii) on active guard and reserve duty?

E. A licensee shall not require a borrower to purchase or maintain property insurance for a motor vehicle from or through a particular provider or list of providers.

F. A licensee shall not knowingly make a motor vehicle title loan to a borrower on the same day that the borrower repaid or satisfied in full a motor vehicle title loan from the same licensee or another licensee. Any motor vehicle title loan made in violation of this subsection shall for purposes of subdivision 17 of § 6.2-2215 of the Code of Virginia be deemed an evasion of the prohibition on refinancing a motor vehicle title loan agreement set forth in § 6.2-2216 F of the Code of Virginia.

G. The maturity date of a motor vehicle title loan shall not be earlier than 120 days from the date a motor vehicle title loan agreement is executed by a borrower or later than 12 months from the date a motor vehicle title loan agreement is executed by a borrower.

H. A licensee shall not electronically debit a borrower's deposit account or otherwise obtain any funds from a borrower by electronic means, including the use of the Automated Clearing House network, electronic funds transfers, electronic check conversions, or re-presented check entries.

I. If a licensee disburses loan proceeds by means of a check, the licensee shall not (i) charge the borrower a fee for cashing the check or (ii) permit either a check casher located in the same office as the licensee or any affiliated check casher to charge the borrower a fee for cashing the check.

J. A borrower shall have the right to cancel a motor vehicle title loan agreement at any time before the close of business on the next business day following the date that the loan agreement is executed by the borrower by returning the original loan proceeds check or paying to the licensee, in the form of cash or good funds instrument, the principal amount advanced to the borrower. If a borrower cancels a loan agreement in accordance with this subsection, the licensee shall upon receipt of the loan proceeds check, cash, or good funds instrument (i) mark the original loan agreement with the word "canceled," return it to the borrower, and retain a copy in its records; and (ii) return the certificate of title to the borrower. Furthermore, the licensee shall not be entitled to charge, contract for, collect, receive, recover, or require a borrower to pay any interest, fees, or other amounts otherwise permitted by § 6.2-2216 of the Code of Virginia.

K. A licensee shall give a borrower a signed, dated receipt for each cash payment made in person, which shall state the balance due on the loan.

L. A borrower shall be permitted to prepay a motor vehicle title loan either in whole or in part without charge. Partial prepayments shall reduce the outstanding loan balance upon which interest is calculated. A licensee may apply a payment first to any amounts that are due and unpaid at the time of such payment.

M. ~~Pursuant to §§ 6.2-2215 and 46.2-643 of the Code of Virginia, a~~ A licensee shall release its security interest and perform the following acts within 10 days after the date that a borrower's obligations under a motor vehicle title loan agreement are satisfied in full: (i) mark the original loan agreement with the word "paid" or "canceled," return it to the borrower, and retain a copy in its records; (ii) take any action necessary to reflect the termination of its lien on the motor vehicle's certificate of title; and (iii) return the certificate of title to the borrower.

N. When sending the written notices and accounting specified by § 6.2-2217 of the Code of Virginia, a licensee shall obtain proof of mailing from the United States Postal Service or other common carrier.

O. A licensee may impose a late charge for failure to make timely payment of any amount due under a motor vehicle title loan agreement provided that (i) the late charge is specified in the loan agreement and (ii) the amount of the late charge does not exceed 5.0% of the amount of the payment. A payment shall be considered to be timely if it is made no later than seven calendar days after the due date specified in the loan agreement.

P. Nothing in the Act or this chapter shall be construed to prohibit a licensee from (i) voluntarily accepting a payment on an outstanding motor vehicle title loan from a borrower after the date that such payment was due to the licensee or (ii) considering a payment to be timely if it is made more than seven calendar days after its due date. However, except as otherwise permitted by the Act and this chapter, the licensee shall not charge, contract for, collect, receive, recover, or require a borrower to pay any additional interest, fees, or other amounts.

Q. Pursuant to subdivision 2 of § 6.2-2201 of the Code of Virginia and subdivision 17 of § 6.2-2215 of the Code of Virginia, a licensee shall not make a motor vehicle title loan that has been arranged or brokered by another person. This provision shall not be construed to prohibit a licensee from

originating motor vehicle title loans through its own employees.

10VAC5-210-60. Annual reporting requirements.

When making the annual report required by § 6.2-2210 of the Code of Virginia, in addition to other information required by the commissioner, a licensee shall provide the following data regarding motor vehicle title loans made ~~to Virginia residents~~ under the Act:

1. The total number and dollar amount of motor vehicle title loans made by the licensee.

2. The total number of individual borrowers to whom motor vehicle title loans were made by the licensee.

3. The minimum, maximum, and average loan amount of motor vehicle title loans made by the licensee.

4. The minimum, maximum, and average Annual Percentage Rate of motor vehicle title loans made by the licensee.

5. The minimum, maximum, and average term (in days) of motor vehicle title loans made by the licensee.

6. The total number of individual borrowers that failed to make a monthly payment on a motor vehicle title loan for at least 60 days.

7. The total number of motor vehicles that were repossessed by or on behalf of the licensee.

8. The total number of repossessed motor vehicles that were sold by or on behalf of the licensee.

9. The total number of personal money judgments against borrowers that were obtained by or on behalf of the licensee along with a breakdown of this total that identifies the number of judgments the licensee pursued based on each of the following borrower actions: (i) intentionally damaging or destroying a motor vehicle that secures a title loan; (ii) intentionally concealing a motor vehicle that secures a title loan; (iii) giving the licensee a lien on a motor vehicle that is already encumbered by an undisclosed prior lien; and (iv) subsequently giving a security interest in, or selling, a motor vehicle that secures a title loan to a third party, without the licensee's written consent.

10VAC5-210-90. Books, accounts, and records; responding to requests from the bureau.

A. A licensee shall maintain in its licensed offices such books, accounts, and records as the bureau may reasonably require in order to determine whether the licensee is complying with the Act and this chapter. Such books, accounts, and records shall be maintained apart and separate from those relating to any other business in which the licensee is involved.

B. In addition to any other books, accounts, and records as the bureau may reasonably require, a licensee shall maintain copies of the following records for at least three years after final payment is made on any motor vehicle title loan:

1. The loan application.

2. The motor vehicle title loan agreement. If a loan has been repaid or satisfied in full, a licensee shall maintain a copy of the motor vehicle title loan agreement with the word "paid" or "canceled" along with documentation showing that the licensee released its security interest in the borrower's motor vehicle.

3. A record of the fair market value of the motor vehicle securing the loan along with supporting documentation from a recognized pricing guide. Supporting documentation shall include any factors used to determine the value of the motor vehicle, including the motor vehicle's condition, features, mileage, as well as the name of the pricing guide that the licensee relied upon in making the loan.

4. Any disclosures that were given to a borrower pursuant to the Truth in Lending Act (15 USC § 1601 et seq.) or any other federal or state laws.

5. The certificate of title for the motor vehicle, which shall reflect the licensee's security interest unless the borrower canceled or fully satisfied the motor vehicle title loan prior to the licensee recording its security interest with the ~~Virginia Department of Motor Vehicles~~ motor vehicle department in the state where the motor vehicle is registered.

C. A licensee shall maintain a repossession log or similar record of all motor vehicles that have been repossessed by or on behalf of the licensee, including motor vehicles that are voluntarily surrendered by borrowers. The log or record shall include the following information: (i) the borrower's first and last name; (ii) the make, model, year, and vehicle identification number of the motor vehicle; (iii) the date the motor vehicle was repossessed; (iv) the date the motor vehicle was sold; (v) the name of the purchaser; and (vi) the sale price of the motor vehicle. Furthermore, in addition to any other books, accounts, and records as the bureau may reasonably require, a licensee shall maintain copies of the following records for at least three years after a motor vehicle used to secure a loan is repossessed and sold by or on behalf of the licensee:

1. The written notices and accounting sent by the licensee to a borrower pursuant to § 6.2-2217 of the Code of Virginia along with the proof of mailing from the United States Postal Service or other common carrier.

2. Supporting documentation of the sale of the motor vehicle and the proceeds derived from the sale.

3. The check or other method of payment used to deliver any excess proceeds from the sale of the motor vehicle to a borrower.

D. A motor vehicle title lender shall retain for at least three years after it is last published, delivered, transmitted, or made available, an example of every advertisement used, including but not limited to solicitation letters, commercial scripts, and recordings of all radio and television broadcasts, but excluding copies of Internet web pages.

E. When the bureau requests a written response, books, records, documentation, or other information from a licensee in connection with the bureau's investigation, enforcement, or examination of compliance with applicable laws, the licensee shall deliver a written response as well as any requested books, records, documentation, or information within the time period specified in the bureau's request. If no time period is specified, a written response as well as any requested books, records, documentation, or information shall be delivered by the licensee to the bureau not later than 30 days from the date of such request. In determining the specified time period for responding to the bureau and when considering a request for an extension of time to respond, the bureau shall take into consideration the volume and complexity of the requested written response, books, records, documentation, or information, and such other factors as the bureau determines to be relevant under the circumstances. Requests made by the bureau pursuant to this subsection are deemed to be in furtherance of the investigation and examination authority provided for in § 6.2-2212 of the Code of Virginia.

F. If a licensee disposes of records containing a consumer's personal financial information following the expiration of any applicable record retention periods, such records shall be shredded, incinerated, or otherwise disposed of in a secure manner. Licensees may arrange for service from a business record destruction vendor.

10VAC5-210-95. Schedule of annual fees for the examination, supervision, and regulation of motor vehicle title lenders.

Pursuant to § 6.2-2213 of the Code of Virginia, the commission sets the following schedule of annual fees to be paid by persons licensed under the Act. The assessment defrays the costs of the examination, supervision, and regulation of licensees by the bureau.

The annual fee shall be $500 per office plus $2.85 per motor vehicle title loan made by each licensee. The annual fee shall be computed on the basis of (i) the number of offices, authorized and opened, as of December 31 of the year preceding the year of the assessment, and (ii) the number of motor vehicle title loans made under the Act during the calendar year preceding the year of the assessment.

The amount calculated using the above schedule shall be rounded down to the nearest whole dollar.

Fees shall be assessed on or before September 15 for the current calendar year. The assessment shall be paid by licensees on or before October 15.

The annual report, due March 25 each year, of each licensee provides the basis for its assessment (i.e., the number of offices and motor vehicle title loans made). In cases where a license has been granted between January 1 and September 15 of the year of the assessment, the licensee shall pay $250 per office, authorized and opened, as of September 15 of that year.

Fees prescribed and assessed pursuant to this schedule are apart from, and do not include, the reimbursement for expenses authorized by subsection B of § 6.2-2213 of the Code of Virginia.

VA.R. Doc. No. R11-2826; Filed May 2, 2011, 11:50 a.m.

TITLE 12. HEALTH

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Final Regulation

REGISTRAR'S NOTICE: The Department of Medical Assistance Services is claiming an exclusion from the Administrative Process Act in accordance with § 2.2-4006 A 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.

Titles of Regulations: **12VAC30-70. Methods and Standards for Establishing Payment Rates - Inpatient Hospital Services (amending 12VAC30-70-50, 12VAC30-70-271, 12VAC30-70-291, 12VAC30-70-331, 12VAC30-70-341, 12VAC30-70-420).**

12VAC30-80. Methods and Standards for Establishing Payment Rates; Other Types of Care (amending 12VAC30-80-20, 12VAC30-80-30, 12VAC30-80-190).

12VAC30-90. Methods and Standards for Establishing Payment Rates for Long-Term Care (amending 12VAC30-90-36, 12VAC30-90-41).

Statutory Authority: §§ 32.1-324 and 32.1-325 of the Code of Virginia.

Effective Date: July 1, 2011.

Agency Contact: Brian McCormick, Regulatory Supervisor, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804)

371-8856, FAX (804) 786-1680, or email brian.mccormick@dmas.virginia.gov.

Background: The Department of Medical Assistance Services (DMAS) implemented rate reductions effective July 1, 2010, affecting many providers as required by the 2010 Appropriation Act. The Appropriation Act also directed DMAS to reverse some of these rate reductions if Congress extended through June 30, 2011, the additional federal funding for Medicaid originally included in the American Recovery and Reinvestment Act of 2009. In early August, Congress passed an extension of the federal funding but at a lower level than originally anticipated. Based on the authority under Item 297 KKKK of the 2010 Appropriation Act, the Governor authorized modifications to the restorations consistent with available funding and rescinded these rate cuts effective for dates of service from October 1, 2010, through June 30, 2011. The 2011 Appropriation Act reversed some of the rate changes and made some additional changes effective July 1, 2011. These 2010 rate changes were implemented based on mandates authorizing DMAS to make reimbursement changes prior to completion of the regulatory process. The 2010 reimbursement changes will be retained in the regulation language for cost settlement and appeal purposes until the settlement and appeal periods have expired.

Summary:

12VAC30-70-50 is amended to eliminate the incentive plan for long stay hospitals effective for dates of service July 1, 2010, to September 30, 2010. Effective for dates of service on or after October 1, 2010, the incentive plan will be reinstated. This change is mandated to comply with Item 297 AAA as modified by the Governor under the authority in Item 297 KKKK for dates of service October 1, 2010, through June 30, 2011.

12VAC30-70-271 is amended to reduce hospital inpatient capital reimbursement from 75% to 72% of cost for Type Two hospitals effective for dates of service July 1, 2010, to September 30, 2010. Effective for dates of service October 1, 2010, through June 30, 2011, hospital capital reimbursement will be reimbursed at 75% of cost for Type Two hospitals. Effective July 1, 2011, hospital capital reimbursement will be decreased to 71% of costs. Corresponding changes will be made for Type One hospitals and Type Two hospitals with greater than 50% Medicaid utilization. These changes are mandated by Item 297 HHHH as modified by the Governor under the authority in Item 297 KKKK for dates of service October 1, 2010, through June 30, 2011.

12VAC30-70-291 is amended effective July 1, 2011, to restore indirect medical education payments to hospitals with high Medicaid neonatal intensive care unit utilization, excluding freestanding children's hospitals. These changes are mandated in Item 297 MMM of the Appropriation Act.

12VAC30-70-331 and 12VAC30-70-341 are amended to reduce the hospital adjustment factor for acute care and rehabilitation inpatient services for Type Two hospitals from 78% to 75% of cost and the adjustment factor for psychiatric inpatient hospital services from 84% to 81% of cost, effective for dates of service July 1, 2010, to September 30, 2010. Effective for dates of service on or after October 1, 2010, the hospital adjustment factor for acute care and rehabilitation inpatient services for Type Two hospitals will be 78% of cost and the adjustment factor for psychiatric inpatient hospital services will be 84% of cost. Corresponding changes will be made for Type One hospitals. These changes are mandated by Item 297 AAAA as modified by the Governor under the authority in Item 297 KKKK for dates of service October 1, 2010, through June 30, 2011.

12VAC30-70-420 is amended to reduce operating rates for out-of-state non cost-reporting hospitals to the lesser of the home states reimbursement or the statewide average of operating rates. This change is mandated by Item 297 ZZZ of the Appropriation Act.

12VAC30-80-20 is amended to reduce outpatient hospital reimbursement from 80% to 77% of cost, effective for dates of service July 1, 2010, to September 30, 2010. Effective for dates of service October 1, 2010, through June 30, 2011, outpatient hospital reimbursement will be 80% of cost. Effective July 1, 2011, outpatient hospital reimbursement will be reduced to 76% of cost. Corresponding changes will be made for Type One hospitals. These changes are mandated by Item 297 BBBB as modified by the Governor under the authority in Item 297 KKKK for dates of service October 1, 2010, through June 30, 2011.

12VAC30-80-30 is amended to establish supplemental payments for physician practices affiliated with freestanding children's hospitals with more than 50% Medicaid inpatient utilization in state fiscal year 2009 based on the difference between the upper payment limit approved by the Centers for Medicare and Medicaid Services and the reimbursement otherwise payable to physicians effective July 1, 2011. DMAS added paragraph 17 to establish and define this new supplemental payment. The first part of paragraph 17 defines the group eligible for the payment, in accordance with Item 297 LLLL. The second paragraph describes the formula used to calculate the payment based on the requirements of the mandate. These changes are mandated by Item 297 LLLL.

12VAC30-80-190 is amended to reduce by 3.0%, the fees for all procedures set through the RBRVS process effective for dates of service July 1, 2010, to September 30, 2010. Effective for dates of service on or after October 1, 2010, the 3.0% reduction to fees for all procedures set through the RBRVS process will be rescinded. These changes are

mandated by Item 297 CCCC as modified by the Governor under the authority in Item 297 KKKK for dates of service October 1, 2010, through June 30, 2011.

12VAC30-90-36 is amended to reduce the nursing facility capital rental rate floor from 9.0% to 8.75% effective for dates of service July 1, 2010, to September 30, 2010. Effective for dates of service October 1, 2010, through June 30, 2011, the nursing facility capital rental rate floor will be 9.0%. Effective July 1, 2011, the nursing facility capital rental rate floor will be reduced to 8.0%. These changes are mandated by Item 297 DDD 1c as modified by the Governor under the authority in Item 297 KKKK for dates of service October 1, 2010, through June 30, 2011.

12VAC30-90-41 is amended to reduce nursing facility operating rates by 3.0% effective for dates of service July 1, 2010, to September 30, 2010. Effective for dates of service on or after October 1, 2010, the 3.0% decrease to nursing facility operating rates will be rescinded. These changes are mandated by Item 297 DDD 1c as modified by the Governor under the authority in Item 297 KKKK for dates of service October 1, 2010, through June 30, 2011.

12VAC30-70-50. Hospital reimbursement system.

The reimbursement system for hospitals includes the following components:

A. 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.

B. 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 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 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 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 shall be adjusted to reflect this change.

Effective on or after July 1, 1989, for providers subject to the prospective payment system, the allowance for inflation 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, as developed by Data Resources, Incorporated, determined in the quarter in which the provider's new fiscal year begins. Such providers 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 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) to the then current allowance for inflation. The escalation factor shall be applied in accordance with the inpatient hospital reimbursement methodology in effect on June 30, 1992. 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.

Effective July 1, 2010, through June 30, 2012, the escalation factor shall be zero. In addition, ceilings shall remain at the same level as the ceilings for long stay hospitals with fiscal year's end of June 30, 2010.

Effective July 1, 2009, the escalation factor shall be equal to the allowance for inflation.

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.

C. Subsequent to June 30, 1992, the group ceilings shall not be recalculated on allowable costs, but shall be updated by the escalator factor.

D. Prospective rates for each hospital shall be based upon the hospital's allowable costs plus the escalator factor, or the appropriate ceilings, or charges; whichever is lower. Except to eliminate costs that are found to be unallowable, no retrospective adjustment shall be made to prospective rates.

Capital and education costs approved pursuant to PRM-15 (§ 400), shall be considered as pass throughs and not part of the calculation. Capital cost is reimbursed the percentage of allowable cost specified in 12VAC30-70-271.

E. 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. Effective for dates of service July 1, 2010, through September 30, 2010, the incentive plan shall be eliminated.

F. Disproportionate share hospitals defined.

The following criteria shall be met before a hospital is determined to be eligible for a disproportionate share payment adjustment.

1. Criteria.

a. A Medicaid inpatient utilization rate in excess of 8% 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

b. 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.

c. Subdivision 1 b of this subsection does not apply to a hospital:

(1) At which the inpatients are predominantly individuals under 18 years of age; or

(2) Which does not offer nonemergency obstetric services as of December 21, 1987.

2. Payment adjustment.

a. Hospitals which have a disproportionately higher level of Medicaid patients shall be allowed a disproportionate share payment adjustment based on the type of hospital and on the individual hospital's Medicaid utilization. There shall be two types of hospitals: (i) Type One, consisting of state-owned teaching hospitals, and (ii) Type Two, consisting of all other hospitals. The Medicaid utilization shall be determined by dividing the number of utilization Medicaid inpatient days by the total number of inpatient days. Each hospital with a Medicaid utilization of over 8.0% shall receive a disproportionate share payment adjustment.

b. For Type One hospitals, the disproportionate share payment adjustment shall be equal to the product of (i) the hospital's Medicaid utilization in excess of 8.0% times 11, times (ii) the lower of the prospective operating cost rate or ceiling. For Type Two hospitals, 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.

c. No payments made under subdivision 1 or 2 of this subsection shall exceed any applicable limitations upon such payments established by federal law or regulations.

G. Outlier adjustments.

1. 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.

2. DMAS shall pay to disproportionate share hospitals (as defined in subsection F of this section) 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 six years of age.

3. The outlier adjustment calculation.

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 identified in subdivision 1 or 2 of this subsection. 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 identified in subdivision 1 or 2 of this subsection.

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 3 a (ii) of this subsection.

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.

4. Pursuant to 12VAC30-50-100, 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 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.

12VAC30-70-271. Payment for capital costs.

A. Inpatient capital costs shall be determined on an allowable cost basis and settled at the hospital's fiscal year end. Allowable cost shall be determined following the methodology described in Supplement 3 (12VAC30-70-10 through 12VAC30-70-130). ~~Inpatient capital costs of Type One hospitals shall continue to be settled at 100% of allowable cost. For services beginning July 1, 2003, and ending June 30, 2009, inpatient capital costs of Type Two hospitals, except those with Virginia Medicaid utilization rates greater than 50%, shall be settled at 80% of allowable cost. For services beginning July 1, 2009, inpatient capital costs of Type Two hospitals, excluding Type Two hospitals with greater than 50% Virginia Medicaid utilization, shall be settled at 75% of allowable cost.~~

B. For hospitals with fiscal years that are in progress and do not begin on July 1, ~~2003, or July 1, 2009,~~ inpatient capital costs for the fiscal year in progress ~~on those dates~~ shall be apportioned ~~between the time period before and the time period after those dates based on the number of calendar months before and after those dates~~ in accordance with subdivisions 1 through 6 of this subsection.

~~Capital~~ 1. Inpatient capital costs apportioned before July 1, 2003, shall be settled at 100% of allowable cost.

2. Effective July 1, 2003, through June 30, 2009, inpatient capital costs of Type One hospitals shall be settled at 100% of allowable cost. Inpatient capital costs of Type Two hospitals shall be settled at 80% of allowable cost.

3. Effective July 1, 2009, through June 30, 2010, inpatient capital costs of Type One hospitals shall be settled at 100% of allowable cost. Inpatient capital costs of Type Two hospitals, excluding hospitals with Virginia Medicaid utilization greater than 50%, shall be settled at 75% of allowable cost. Inpatient capital costs of Type Two hospitals with Virginia Medicaid utilization greater than 50% shall be settled at 80% of allowable cost.

4. Effective July 1, 2010, through September 30, 2010, inpatient capital costs of Type One hospitals shall be settled at 97% of allowable costs. Inpatient capital costs of Type Two hospitals, excluding hospitals with Virginia Medicaid utilization greater than 50%, shall be settled at 72% of allowable cost. Inpatient capital costs of Type Two hospitals with Virginia Medicaid utilization greater than 50% shall be settled at 77% of allowable cost.

5. Effective October 1, 2010, through June 30, 2011, inpatient capital costs of Type One hospitals shall be settled at 100% of allowable cost. Inpatient capital costs of Type Two hospitals, excluding hospitals with Virginia Medicaid utilization greater than 50%, shall be settled at 75% of allowable cost. Inpatient capital costs of Type Two hospitals with Virginia Medicaid utilization greater than 50% shall be settled at 80% of allowable cost.

6. Effective July 1, 2011, inpatient capital costs of Type One hospitals shall be settled at 96% of allowable costs. Inpatient capital costs of Type Two hospitals, excluding hospitals with Virginia Medicaid utilization greater than 50%, shall be settled at 71% of allowable cost. Inpatient capital costs of Type Two hospitals with Virginia Medicaid utilization greater than 50% shall be settled at 76% of allowable cost.

~~B.~~ C. The exception to the policy in subsection A of this section is that the hospital specific rate per day for services in

freestanding psychiatric facilities licensed as hospitals, as determined in 12VAC30-70-321 B, shall be an all-inclusive payment for operating and capital costs. The capital rate per day determined in 12VAC30-70-321 will be multiplied by the same percentage of allowable cost specified in subsection ~~A~~ B of this section.

12VAC30-70-291. Payment for indirect medical education costs.

A. Hospitals shall be eligible to receive payments for indirect medical education. Out-of-state cost reporting hospitals are eligible for this payment only if they have Virginia Medicaid utilization in the base year of at least 12% of total Medicaid days. These payments recognize the increased use of ancillary services associated with the educational process and the higher case-mix intensity of teaching hospitals. The payments for indirect medical education shall be made in estimated quarterly lump sum amounts and settled at the hospital's fiscal year end.

B. Final payment for IME shall be determined as follows:

1. Type One hospitals shall receive an IME payment equal to the hospital's Medicaid operating reimbursement times an IME percentage determined as follows:

IME Percentage for Type One Hospitals = [1.89 X ((1 + r)$^{0.405}$-1)] X (IME Factor)

An IME factor shall be calculated for each Type One hospital and shall equal a factor that, when used in the calculation of the IME percentage, shall cause the resulting IME payments to equal what the IME payments would be with an IME factor of one, plus an amount equal to the difference between operating payments using the adjustment factor specified in subdivision B 1 of 12VAC30-70-331 and operating payments using an adjustment factor of one in place of the adjustment factor specified in subdivision B 1 of 12VAC30-70-331.

2. Type Two hospitals shall receive an IME payment equal to the hospital's Medicaid operating reimbursement times an IME percentage determined as follows:

IME Percentage for Type Two Hospitals = [1.89 X ((1 + r)$^{0.405}$-1)] X 0.5695

In both equations, r is the ratio of full-time equivalent residents to staffed beds, excluding nursery beds. The IME payment shall be calculated each year using the most recent reliable data regarding the number of full-time equivalent residents and the number of staffed beds, excluding nursery beds.

C. An additional IME payment shall be made for inpatient hospital services provided to Medicaid patients but reimbursed by capitated managed care providers. This payment shall be equal to the hospital's hospital specific operating rate per case, as determined in 12VAC30-70-311, times the hospital's HMO paid discharges times the hospital's IME percentage, as determined in subsection B of this section.

D. An additional IME payment not to exceed ~~$1.9 million~~ $200,000 in total shall be apportioned among Type Two ~~Hospitals~~ hospitals, excluding freestanding children's hospitals, with Medicaid NICU utilization in excess of 50% ~~and with overall Medicaid utilization in excess of 50%~~ as reported to the Department of Medical Assistance Services as of March 1, 2004. These payments shall be apportioned based on each eligible hospital's percentage of Medicaid NICU patient days relative to the total of these days among eligible hospitals as reported by March 1, 2004.

E. An additional IME payment not to exceed $500,000 in total shall be apportioned among Type Two hospitals, excluding freestanding children's hospitals, with Medicaid NICU days in excess of 4,500 as reported to the Department of Medical Assistance Services as of March 1, 2005, that do not otherwise receive an additional IME payment under subsection D of this section. These payments shall be apportioned based on each eligible hospital's percentage of Medicaid NICU patient days relative to the total of these days among eligible hospitals as reported by March 1, 2003.

12VAC30-70-331. Statewide operating rate per case.

A. The statewide operating rate per case shall be equal to the base year standardized operating costs per case, as determined in 12VAC30-70-361, times the inflation values specified in 12VAC30-70-351 times the adjustment factor specified in subsection B of this section.

B. The adjustment factor shall be determined separately for Type One and Type Two hospitals:

1. For Type One hospitals the adjustment factor shall be a calculated percentage that causes the Type One hospital statewide operating rate per case to equal the Type Two hospital statewide operating rate per case;

2. ~~Effective July 1, 2006, for~~ For Type Two hospitals the adjustment factor shall be:

a. 0.7800 effective July 1, 2006, through June 30, 2010.

b. 0.7500 effective July 1, 2010, through September 30, 2010.

c. 0.7800 effective October 1, 2010.

12VAC30-70-341. Statewide operating rate per day.

A. The statewide operating rate per day shall be equal to the base year standardized operating costs per day, as determined in subsection B of 12VAC30-70-371, times the inflation values specified in 12VAC30-70-351 times the adjustment factor specified in subsection B or C of this section.

B. The adjustment factor for acute care rehabilitation cases shall be the one specified in subsection B of 12VAC30-70-331.

C. ~~The adjustment factor for acute care psychiatric cases for Type Two hospitals shall be 0.8400.~~ The adjustment factor for acute care psychiatric cases for:

1. Type One hospitals shall be the one specified in subdivision B 1 of 12VAC30-70-331 times ~~0.8400~~ the factor in subdivision 2 this subsection divided by the factor in subdivision B 2 of 12VAC30-70-331.

2. Type Two hospitals shall be:

a. 0.7800 effective July 1, 2006, through June 30, 2007.

b. 0.8400 effective July 1, 2007, through June 30, 2010.

c. 0.8100 effective July 1, 2010, through September 30, 2010.

d. 0.8400 effective October 1, 2010.

D. Effective July 1, 2009, for freestanding psychiatric facilities, the adjustment factor shall be 1.0000.

12VAC30-70-420. Reimbursement of noncost-reporting general acute care hospital providers.

A. Effective July 1, 2000, noncost-reporting (general acute care hospitals that are not required to file cost reports) shall be paid based on DRG rates unadjusted for geographic variation increased by the average capital percentage among hospitals filing cost reports in a recent year. General acute care hospitals shall not file cost reports if they have less than 1,000 days per year (in the most recent provider fiscal year) of inpatient utilization by Virginia Medicaid recipients, inclusive of patients in managed care capitation programs.

B. Effective July 1, 2011, out-of-state hospitals shall be reimbursed the lesser of the amount reimbursed by the Medicaid program in the facility's home state or the rate defined in the subsection A of this section.

C. Prior approval must be received from DMAS when a referral has been made for treatment to be received from a nonparticipating acute care facility (in-state or out-of-state). Prior approval will be granted for inpatient hospital services provided out of state to a Medicaid recipient who is a resident of the Commonwealth of Virginia under any one of the following conditions. It shall be the responsibility of the nonparticipating hospital, when requesting prior authorization for the admission of the Virginia resident, to demonstrate that one of the following conditions exists in order to obtain authorization. Services provided out of state for circumstances other than these specified reasons shall not be covered.

1. The medical services must be needed because of a medical emergency;

2. Medical services must be needed and the recipient's health would be endangered if he were required to travel to his state of residence;

3. The state determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state;

4. It is general practice for recipients in a particular locality to use medical resources in another state.

12VAC30-80-20. Services that are reimbursed on a cost basis.

A. Payments for services listed below shall be on the basis of reasonable cost following the standards and principles applicable to the Title XVIII Program with the exception provided for in subdivision D 1 d. The upper limit for reimbursement shall be no higher than payments for Medicare patients on a facility by facility basis in accordance with 42 CFR 447.321 and 42 CFR 447.325. In no instance, however, shall charges for beneficiaries of the program be in excess of charges for private patients receiving services from the provider. The professional component for emergency room physicians shall continue to be uncovered as a component of the payment to the facility.

B. Reasonable costs will be determined from the filing of a uniform cost report by participating providers. The cost reports are due not later than 150 days after the provider's fiscal year end. If a complete cost report is not received within 150 days after the end of the provider's fiscal year, the Program shall take action in accordance with its policies to assure that an overpayment is not being made. The cost report will be judged complete when DMAS has all of the following:

1. Completed cost reporting form(s) provided by DMAS, with signed certification(s);

2. The provider's trial balance showing adjusting journal entries;

3. The provider's financial statements including, but not limited to, a balance sheet, a statement of income and expenses, a statement of retained earnings (or fund balance), and a statement of changes in financial position;

4. Schedules that reconcile financial statements and trial balance to expenses claimed in the cost report;

5. Depreciation schedule or summary;

6. Home office cost report, if applicable; and

7. Such other analytical information or supporting documents requested by DMAS when the cost reporting forms are sent to the provider.

C. Item 398 D of the 1987 Appropriation Act (as amended), effective April 8, 1987, eliminated reimbursement of return on equity capital to proprietary providers.

D. The services that are cost reimbursed are:

1. Outpatient hospital services including rehabilitation hospital outpatient services and excluding laboratory.

a. Definitions. The following words and terms when used in this regulation shall have the following meanings when applied to emergency services unless the context clearly indicates otherwise:

"All-inclusive" means all emergency department and ancillary service charges claimed in association with the emergency room visit, with the exception of laboratory services.

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

"Emergency hospital services" means services that are necessary to prevent the death or serious impairment of the health of the recipient. The threat to the life or health of the recipient necessitates the use of the most accessible hospital available that is equipped to furnish the services.

"Recent injury" means an injury that has occurred less than 72 hours prior to the emergency department visit.

b. Scope. DMAS shall differentiate, as determined by the attending physician's diagnosis, the kinds of care routinely rendered in emergency departments and reimburse for nonemergency care rendered in emergency departments at a reduced rate.

(1) With the exception of laboratory services, DMAS shall reimburse at a reduced and all-inclusive reimbursement rate for all services, including those obstetric and pediatric procedures contained in 12VAC30-80-160, rendered in emergency departments that DMAS determines were nonemergency care.

(2) Services determined by the attending physician to be emergencies shall be reimbursed under the existing methodologies and at the existing rates.

(3) Services performed by the attending physician that may be emergencies shall be manually reviewed. If such services meet certain criteria, they shall be paid under the methodology for subdivision 1 b (2) of this subsection. Services not meeting certain criteria shall be paid under the methodology of subdivision 1 b (1) of this subsection. Such criteria shall include, but not be limited to:

(a) The initial treatment following a recent obvious injury.

(b) Treatment related to an injury sustained more than 72 hours prior to the visit with the deterioration of the symptoms to the point of requiring medical treatment for stabilization.

(c) The initial treatment for medical emergencies including indications of severe chest pain, dyspnea, gastrointestinal hemorrhage, spontaneous abortion, loss of consciousness, status epilepticus, or other conditions considered life threatening.

(d) A visit in which the recipient's condition requires immediate hospital admission or the transfer to another facility for further treatment or a visit in which the recipient dies.

(e) Services provided for acute vital sign changes as specified in the provider manual.

(f) Services provided for severe pain when combined with one or more of the other guidelines.

(4) Payment shall be determined based on ICD-9-CM diagnosis codes and necessary supporting documentation.

(5) DMAS shall review on an ongoing basis the effectiveness of this program in achieving its objectives and for its effect on recipients, physicians, and hospitals. Program components may be revised subject to achieving program intent, the accuracy and effectiveness of the ICD-9-CM code designations, and the impact on recipients and providers.

c. Limitation ~~to 80%~~ of allowable cost. Effective for services on and after July 1, 2003, reimbursement of Type Two hospitals for outpatient services shall be at ~~80%~~ various percentages as noted in subdivisions 1 c (1) and (2) of this subsection of allowable cost, with cost to be determined as provided in subsections A, B, and C of this section. For hospitals with fiscal years that do not begin on July 1, ~~2003,~~ outpatient costs, both operating and capital, for the fiscal year in progress on that date shall be apportioned between the time period before and the time period after that date, based on the number of calendar months in the cost reporting period, falling before and after that date. ~~Operating costs apportioned before that date shall be settled according to the principles in effect before that date, and those after at 80% of allowable cost. Capital costs apportioned before that date shall be settled according to the principles in effect before that date, and those after at 80% of allowable cost. Operating and capital costs of Type One hospitals shall continue to be reimbursed at 94.2% and 90% of cost respectively.~~

~~d. Outpatient reimbursement methodology prior to July 1, 2003. DMAS shall continue to reimburse for outpatient hospital services, with the exception of direct graduate medical education for interns and residents, at~~

~~100% of reasonable costs less a 10% reduction for allowable capital costs and a 5.8% reduction for allowable operating costs. This methodology shall continue to be in effect after July 1, 2003, for Type One hospitals.~~

(1) Type One hospitals.

(a) Effective July 1, 2003, through June 30, 2010, hospital outpatient operating reimbursement shall be at 94.2% of allowable cost and capital reimbursement shall be at 90% of allowable cost.

(b) Effective July 1, 2010, through September 30, 2010, hospital outpatient operating reimbursement shall be at 91.2% of allowable cost and capital reimbursement shall be at 87% of allowable cost.

(c) Effective October 1, 2010, through June 30, 2011, hospital outpatient operating reimbursement shall be at 94.2% of allowable cost and capital reimbursement shall be at 90% of allowable cost.

(d) Effective July 1, 2011, hospital outpatient operating reimbursement shall be at 90.2% of allowable cost and capital reimbursement shall be at 86% of allowable cost.

(2) Type Two hospitals.

(a) Effective July 1, 2003, through June 30, 2010, hospital outpatient operating and capital reimbursement shall be 80% of allowable cost.

(b) Effective July 1, 2010, through September 30, 2010, hospital outpatient operating and capital reimbursement shall be 77% of allowable cost.

(c) Effective October 1, 2010, through June 30, 2011, hospital outpatient operating and capital reimbursement shall be 80% of allowable cost.

(d) Effective July 1, 2011, hospital outpatient operating and capital reimbursement shall be 76% of allowable cost.

~~e.~~ d. Payment for direct medical education costs of nursing schools, paramedical programs and graduate medical education for interns and residents.

(1) Direct medical education costs of nursing schools and paramedical programs shall continue to be paid on an allowable cost basis.

(2) Effective with cost reporting periods beginning on or after July 1, 2002, direct graduate medical education (GME) costs for interns and residents shall be reimbursed on a per-resident prospective basis. See 12VAC30-70-281 for prospective payment methodology for graduate medical education for interns and residents.

2. Rehabilitation agencies operated by community services boards. For reimbursement methodology applicable to other rehabilitation agencies, see 12VAC30-80-200. Reimbursement for physical therapy, occupational therapy, and speech-language therapy services shall not be provided for any sums that the rehabilitation provider collects, or is entitled to collect, from the NF or any other available source, and provided further, that this amendment shall in no way diminish any obligation of the NF to DMAS to provide its residents such services, as set forth in any applicable provider agreement.

12VAC30-80-30. Fee-for-service providers.

A. Payment for the following services, except for physician services, shall be the lower of the state agency fee schedule (12VAC30-80-190 has information about the state agency fee schedule) or actual charge (charge to the general public):

1. Physicians' services. Payment for physician services shall be the lower of the state agency fee schedule or actual charge (charge to the general public). The following limitations shall apply to emergency physician services.

a. Definitions. The following words and terms, when used in this subdivision 1 shall have the following meanings when applied to emergency services unless the context clearly indicates otherwise:

"All-inclusive" means all emergency service and ancillary service charges claimed in association with the emergency department visit, with the exception of laboratory services.

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

"Emergency physician services" means services that are necessary to prevent the death or serious impairment of the health of the recipient. The threat to the life or health of the recipient necessitates the use of the most accessible hospital available that is equipped to furnish the services.

"Recent injury" means an injury that has occurred less than 72 hours prior to the emergency department visit.

b. Scope. DMAS shall differentiate, as determined by the attending physician's diagnosis, the kinds of care routinely rendered in emergency departments and reimburse physicians for nonemergency care rendered in emergency departments at a reduced rate.

(1) DMAS shall reimburse at a reduced and all-inclusive reimbursement rate for all physician services, including those obstetric and pediatric procedures contained in 12VAC30-80-160, rendered in emergency departments that DMAS determines are nonemergency care.

(2) Services determined by the attending physician to be emergencies shall be reimbursed under the existing methodologies and at the existing rates.

(3) Services determined by the attending physician that may be emergencies shall be manually reviewed. If such services meet certain criteria, they shall be paid under the methodology in subdivision 1 b (2) of this subsection. Services not meeting certain criteria shall be paid under the methodology in subdivision 1 b (1) of this subsection. Such criteria shall include, but not be limited to:

(a) The initial treatment following a recent obvious injury.

(b) Treatment related to an injury sustained more than 72 hours prior to the visit with the deterioration of the symptoms to the point of requiring medical treatment for stabilization.

(c) The initial treatment for medical emergencies including indications of severe chest pain, dyspnea, gastrointestinal hemorrhage, spontaneous abortion, loss of consciousness, status epilepticus, or other conditions considered life threatening.

(d) A visit in which the recipient's condition requires immediate hospital admission or the transfer to another facility for further treatment or a visit in which the recipient dies.

(e) Services provided for acute vital sign changes as specified in the provider manual.

(f) Services provided for severe pain when combined with one or more of the other guidelines.

(4) Payment shall be determined based on ICD-9-CM diagnosis codes and necessary supporting documentation.

(5) DMAS shall review on an ongoing basis the effectiveness of this program in achieving its objectives and for its effect on recipients, physicians, and hospitals. Program components may be revised subject to achieving program intent objectives, the accuracy and effectiveness of the ICD-9-CM code designations, and the impact on recipients and providers.

2. Dentists' services.

3. Mental health services including: (i) community mental health services; (ii) services of a licensed clinical psychologist; or (iii) mental health services provided by a physician.

a. Services provided by licensed clinical psychologists shall be reimbursed at 90% of the reimbursement rate for psychiatrists.

b. Services provided by independently enrolled licensed clinical social workers, licensed professional counselors or licensed clinical nurse specialists-psychiatric shall be reimbursed at 75% of the reimbursement rate for licensed clinical psychologists.

4. Podiatry.

5. Nurse-midwife services.

6. Durable medical equipment (DME).

a. For those items that have a national Healthcare Common Procedure Coding System (HCPCS) code, the rate for durable medical equipment shall be set at the Durable Medical Equipment Regional Carrier (DMERC) reimbursement level.

b. The rate paid for all items of durable medical equipment except nutritional supplements shall be the lower of the state agency fee schedule that existed prior to July 1, 1996, less 4.5%, or the actual charge.

c. The rate paid for nutritional supplements shall be the lower of the state agency fee schedule or the actual charge.

d. Certain durable medical equipment used for intravenous therapy and oxygen therapy shall be bundled under specified procedure codes and reimbursed as determined by the agency. Certain services/durable medical equipment such as service maintenance agreements shall be bundled under specified procedure codes and reimbursed as determined by the agency.

(1) Intravenous therapies. The DME for a single therapy, administered in one day, shall be reimbursed at the established service day rate for the bundled durable medical equipment and the standard pharmacy payment, consistent with the ingredient cost as described in 12VAC30-80-40, plus the pharmacy service day and dispensing fee. Multiple applications of the same therapy shall be included in one service day rate of reimbursement. Multiple applications of different therapies administered in one day shall be reimbursed for the bundled durable medical equipment service day rate as follows: the most expensive therapy shall be reimbursed at 100% of cost; the second and all subsequent most expensive therapies shall be reimbursed at 50% of cost. Multiple therapies administered in one day shall be reimbursed at the pharmacy service day rate plus 100% of every active therapeutic ingredient in the compound (at the lowest ingredient cost methodology) plus the appropriate pharmacy dispensing fee.

(2) Respiratory therapies. The DME for oxygen therapy shall have supplies or components bundled under a service day rate based on oxygen liter flow rate or blood gas levels. Equipment associated with respiratory therapy may have ancillary components bundled with the main component for reimbursement. The reimbursement shall be a service day per diem rate for rental of equipment or a total amount of purchase for the purchase of equipment. Such respiratory equipment shall include, but not be limited to, oxygen tanks and tubing, ventilators, noncontinuous ventilators, and suction machines. Ventilators, noncontinuous ventilators, and suction

machines may be purchased based on the individual patient's medical necessity and length of need.

(3) Service maintenance agreements. Provision shall be made for a combination of services, routine maintenance, and supplies, to be known as agreements, under a single reimbursement code only for equipment that is recipient owned. Such bundled agreements shall be reimbursed either monthly or in units per year based on the individual agreement between the DME provider and DMAS. Such bundled agreements may apply to, but not necessarily be limited to, either respiratory equipment or apnea monitors.

7. Local health services.

8. Laboratory services (other than inpatient hospital).

9. Payments to physicians who handle laboratory specimens, but do not perform laboratory analysis (limited to payment for handling).

10. X-Ray services.

11. Optometry services.

12. Medical supplies and equipment.

13. Home health services. Effective June 30, 1991, cost reimbursement for home health services is eliminated. A rate per visit by discipline shall be established as set forth by 12VAC30-80-180.

14. Physical therapy; occupational therapy; and speech, hearing, language disorders services when rendered to noninstitutionalized recipients.

15. Clinic services, as defined under 42 CFR 440.90.

16. Supplemental payments for services provided by Type I physicians.

a. In addition to payments for physician services specified elsewhere in this State Plan, DMAS provides supplemental payments to Type I physicians for furnished services provided on or after July 2, 2002. A Type I physician is a member of a practice group organized by or under the control of a state academic health system or an academic health system that operates under a state authority and includes a hospital, who has entered into contractual agreements for the assignment of payments in accordance with 42 CFR 447.10.

b. Effective July 2, 2002, the supplemental payment amount for Type I physician services shall be the difference between the Medicaid payments otherwise made for Type I physician services and Medicare rates. Effective August 13, 2002, the supplemental payment amount for Type I physician services shall be the difference between the Medicaid payments otherwise made for physician services and 143% of Medicare rates. This percentage was determined by dividing the total commercial allowed amounts for Type I physicians for at least the top five commercial insurers in CY 2004 by what Medicare would have allowed. The average commercial allowed amount was determined by multiplying the relative value units times the conversion factor for RBRVS procedures and by multiplying the unit cost times anesthesia units for anesthesia procedures for each insurer and practice group with Type I physicians and summing for all insurers and practice groups. The Medicare equivalent amount was determined by multiplying the total commercial relative value units for Type I physicians times the Medicare conversion factor for RBRVS procedures and by multiplying the Medicare unit cost times total commercial anesthesia units for anesthesia procedures for all Type I physicians and summing.

c. Supplemental payments shall be made quarterly.

d. Payment will not be made to the extent that this would duplicate payments based on physician costs covered by the supplemental payments.

17. Supplemental payments for services provided by physicians at Virginia freestanding children's hospitals.

a. In addition to payments for physician services specified elsewhere in this State Plan, DMAS provides supplemental payments to Virginia freestanding children's hospital physicians providing services at freestanding children's hospitals with greater than 50% Medicaid inpatient utilization in state fiscal year 2009 for furnished services provided on or after July 1, 2011. A freestanding children's hospital physician is a member of a practice group (i) organized by or under control of a qualifying Virginia freestanding children's hospital, or (ii) who has entered into contractual agreements for provision of physician services at the qualifying Virginia freestanding children’s hospital and that is designated in writing by the Virginia freestanding children's hospital as a practice plan for the quarter for which the supplemental payment is made subject to DMAS approval. The freestanding children's hospital physicians also must have entered into contractual agreements with the practice plan for the assignment of payments in accordance with 42 CFR 447.10.

b. Effective July 1, 2011, the supplemental payment amount for freestanding children's hospital physician services shall be the difference between the Medicaid payments otherwise made for freestanding children's hospital physician services and 143% of Medicare rates as defined in the supplemental payment calculation for Type I physician services subject to the following reduction. Final payments shall be reduced on a pro-rated basis so that total payments for freestanding children's hospital physician services are $400,000 less annually than would be calculated based on the formula in the

previous sentence. Payments shall be made on the same schedule as Type I physicians.

~~17.~~ 18. Supplemental payments to nonstate government-owned or operated clinics.

a. In addition to payments for clinic services specified elsewhere in the regulations, DMAS provides supplemental payments to qualifying nonstate government-owned or operated clinics for outpatient services provided to Medicaid patients on or after July 2, 2002. Clinic means a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. Outpatient services include those furnished by or under the direction of a physician, dentist or other medical professional acting within the scope of his license to an eligible individual. Effective July 1, 2005, a qualifying clinic is a clinic operated by a community services board. The state share for supplemental clinic payments will be funded by general fund appropriations.

b. The amount of the supplemental payment made to each qualifying nonstate government-owned or operated clinic is determined by:

(1) Calculating for each clinic the annual difference between the upper payment limit attributed to each clinic according to subdivision ~~17~~ 18 d and the amount otherwise actually paid for the services by the Medicaid program;

(2) Dividing the difference determined in subdivision ~~17~~ 18 b (1) for each qualifying clinic by the aggregate difference for all such qualifying clinics; and

(3) Multiplying the proportion determined in ~~subdivision (2) of this~~ subdivision ~~17~~ 18 b (2) by the aggregate upper payment limit amount for all such clinics as determined in accordance with 42 CFR 447.321 less all payments made to such clinics other than under this section.

c. Payments for furnished services made under this section may be made in one or more installments at such times, within the fiscal year or thereafter, as is determined by DMAS.

d. To determine the aggregate upper payment limit referred to in subdivision ~~17~~ 18 b (3), Medicaid payments to nonstate government-owned or operated clinics will be divided by the "additional factor" whose calculation is described in Attachment 4.19-B, Supplement 4 (12VAC30-80-190 B 2) in regard to the state agency fee schedule for RBRVS. Medicaid payments will be estimated using payments for dates of service from the prior fiscal year adjusted for expected claim payments. Additional adjustments will be made for any program changes in Medicare or Medicaid payments.

~~18. Reserved.~~

19. Personal Assistance Services (PAS) for individuals enrolled in the Medicaid Buy-In program described in 12VAC30-60-200. These services are reimbursed in accordance with the state agency fee schedule described in 12VAC30-80-190. The state agency fee schedule is published on the Single State Agency Website.

B. Hospice services payments must be no lower than the amounts using the same methodology used under Part A of Title XVIII, and take into account the room and board furnished by the facility, equal to at least 95% of the rate that would have been paid by the state under the plan for facility services in that facility for that individual. Hospice services shall be paid according to the location of the service delivery and not the location of the agency's home office.

12VAC30-80-190. State agency fee schedule for RBRVS.

A. Reimbursement of fee-for-service providers. Effective for dates of service on or after July 1, 1995, the Department of Medical Assistance Services (DMAS) shall reimburse fee-for-service providers, with the exception of home health services (see 12VAC30-80-180) and durable medical equipment services (see 12VAC30-80-30), using a fee schedule that is based on a Resource Based Relative Value Scale (RBRVS).

B. Fee schedule.

1. For those services or procedures which are included in the RBRVS published by the Centers for Medicare and Medicaid Services (CMS) as amended from time to time, DMAS' fee schedule shall employ the Relative Value Units (RVUs) developed by CMS as periodically updated.

a. Effective for dates of service on or after July 1, 2008, DMAS shall implement site of service differentials and employ both nonfacility and facility RVUs. The implementation shall be budget neutral using the methodology in subdivision 2 of this subsection.

b. The implementation of site of service shall be transitioned over a four-year period.

(1) Effective for dates of service on or after July 1, 2008, DMAS shall calculate the transitioned facility RVU by adding 75% of the difference between the nonfacility RVU and nonfacility RVU to the facility RVU.

(2) Effective for dates of service on or after July 1, 2009, DMAS shall calculate the transitioned facility RVU by adding 50% of the difference between the nonfacility RVU and nonfacility RVU to the facility RVU.

(3) Effective for dates of service on or after July 1, 2010, DMAS shall calculate the transitioned facility RVU by adding 25% of the difference between the nonfacility RVU and nonfacility RVU to the facility RVU.

(4) Effective for dates of service on or after July 1, 2011, DMAS shall use the unadjusted Medicare facility RVU.

2. DMAS shall calculate the RBRVS-based fees using conversion factors (CFs) published from time to time by CMS. DMAS shall adjust CMS' CFs by additional factors so that no change in expenditure will result solely from the implementation of the RBRVS-based fee schedule. DMAS may revise the additional factors when CMS updates its RVUs or CFs so that no change in expenditure will result solely from such updates. Except for this adjustment, DMAS' CFs shall be the same as those published from time to time by CMS. The calculation of the additional factors shall be based on the assumption that no change in services provided will occur as a result of these changes to the fee schedule. The determination of the additional factors required above shall be accomplished by means of the following calculation:

a. The estimated amount of DMAS expenditures if DMAS were to use Medicare's RVUs and CFs without modification, is equal to the sum, across all relevant procedure codes, of the RVU value published by the CMS, multiplied by the applicable conversion factor published by the CMS, multiplied by the number of occurrences of the procedure code in DMAS patient claims in the most recent period of time (at least six months).

b. The estimated amount of DMAS expenditures, if DMAS were not to calculate new fees based on the new CMS RVUs and CFs, is equal to the sum, across all relevant procedure codes, of the existing DMAS fee multiplied by the number of occurrences of the procedures code in DMAS patient claims in the period of time used in subdivision 2 a of this subsection.

c. The relevant additional factor is equal to the ratio of the expenditure estimate (based on DMAS fees in subdivision 2 b of this subsection) to the expenditure estimate based on unmodified CMS values in subdivision 2 a of this subsection.

d. DMAS shall calculate a separate additional factor for:

(1) Emergency room services (defined as the American Medical Association's (AMA) publication of the Current Procedural Terminology (CPT) codes 99281, 99282, 99283, 99284, and 992851 in effect at the time the service is provided);

(2) Obstetrical/gynecological services (defined as maternity care and delivery procedures, female genital system procedures, obstetrical/gynecological-related radiological procedures, and mammography procedures, as defined by the American Medical Association's (AMA) publication of the Current Procedural Terminology (CPT) manual in effect at the time the service is provided);

(3) Pediatric preventive services (defined as preventive E&M procedures, excluding those listed in subdivision 2 d (1) of this subsection, as defined by the AMA's publication of the CPT manual, in effect at the time the service is provided, for recipients under age 21);

(4) Pediatric primary services (defined as evaluation and management (E&M) procedures, excluding those listed in subdivisions 2 d (1) and 2 d (3) of this subsection, as defined by the AMA's publication of the CPT manual, in effect at the time the service is provided, for recipients under age 21);

(5) Adult primary and preventive services (defined as E&M procedures, excluding those listed in subdivision 2 d (1) of this subsection, as defined by the AMA's publication of the CPT manual, in effect at the time the service is provided, for recipients age 21 and over); and

(6) All other procedures set through the RBRVS process combined.

3. For those services or procedures for which there are no established RVUs, DMAS shall approximate a reasonable relative value payment level by looking to similar existing relative value fees. If DMAS is unable to establish a relative value payment level for any service or procedure, the fee shall not be based on a RBRVS, but shall instead be based on the previous fee-for-service methodology.

4. Fees shall not vary by geographic locality.

5. Effective for dates of service on or after July 1, 2007, fees for emergency room services (defined in subdivision 2 d (1) of this subsection) shall be increased by 5.0% relative to the fees that would otherwise be in effect.

C. Effective for dates of service on or after May 1, 2006, fees for obstetrical/gynecological services (defined in subdivision B 2 d (2) of this section) shall be increased by 2.5% relative to the fees in effect on July 1, 2005.

D. Effective for dates of service on or after May 1, 2006, fees for pediatric services (defined in subdivisions B 2 d (3) and (4) of this section) shall be increased by 5.0% relative to the fees in effect on July 1, 2005. Effective for dates of service on or after July 1, 2006, fees for pediatric services (defined in subdivisions B 2 d (3) and (4) of this section) shall be increased by 5.0% relative to the fees in effect on May 1, 2006. Effective for dates of service on or after July 1, 2007, fees for pediatric primary services (defined in subdivision B 2 d (4) of this section) shall be increased by 10% relative to the fees that would otherwise be in effect.

E. Effective for dates of service on or after July 1, 2007, fees for pediatric preventive services (defined in subdivision B 2 d (3) of this section) shall be increased by 10% relative to the fees that would otherwise be in effect.

F. Effective for dates of service on or after May 1, 2006, fees for adult primary and preventive services (defined in subdivision B 2 d (4) of this section) shall be increased by

5.0% relative to the fees in effect on July 1, 2005. Effective for dates of service on or after July 1, 2007, fees for adult primary and preventive services (defined in subdivision B 2 d (5) of this section) shall be increased by 5.0% relative to the fees that would otherwise be in effect.

G. Effective for dates of service on or after July 1, 2007, fees for all other procedures set through the RBRVS process combined (defined in subdivision B 2 d (6) of this section) shall be increased by 5.0% relative to the fees that would otherwise be in effect.

H. Effective for dates of service on or after July 1, 2010, fees for all procedures set through the RBRVS process shall be decreased by 3.0% relative to the fees that would otherwise be in effect. ~~However, if the increased federal medical assistance percentage under the American Recovery and Reinvestment Act (P.L. 111-5) is extended through June 30, 2011, as provided in Item 297 CCCC.3 of the 2010 Virginia Acts of Assembly, the reduction in this subsection shall not become effective.~~

~~I. Effective for dates of service on or after July 1, 2011, fees for all procedures set through the RBRVS process shall be decreased by 4.0% relative to the fees that would have been in effect except for the provisions of subsection H of this section. However, if the increased federal medical assistance percentage under the American Recovery and Reinvestment Act (P.L. 111-5) is extended through June 30, 2011, as provided in Item 297 CCCC.3 of the 2010 Virginia Acts of Assembly, the reduction in this subsection shall not become effective~~.

I. Effective for dates of service on or after October 1, 2010, through June 30, 2011, the 3.0% fee decrease in subsection H of this section shall no longer be in effect.

12VAC30-90-36. Nursing Facility Capital Payment Methodology.

A. Applicability. The capital payment methodology described in this article shall be applicable to freestanding nursing facilities but not to hospital-based facilities. Hospital-based facilities shall continue to be reimbursed under the methodology contained in Article 2 (12VAC30-90-30 et seq.) of this subpart. For purposes of this provision, a hospital-based nursing facility shall be one for which a combined cost report is submitted on behalf of both the hospital and the nursing facility.

B. Definitions. The following words and terms when used in this article shall have the following meaning unless the context clearly indicates otherwise:

"Capital costs" means costs that include the cost elements of depreciation, interest, financing costs, rent and lease costs for property, building and equipment, property insurance and property taxes.

"Date of acquisition" means the date legal title passed to the buyer. If a legal titling date is not determinable for a nursing facility building, 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.

"Facility average age" means for a facility the weighted average of the ages of all capitalized assets of the facility, with the weights equal to the expenditures for those assets. The calculation of average age shall take into account land improvements, building and fixed equipment, and major movable equipment. The basis for the calculation of average age shall be the schedule of assets submitted annually to the department in accordance with the provisions of this section.

"Facility imputed gross square feet" means a number that is determined by multiplying the facility's number of nursing facility licensed beds licensed by the Virginia Department of Health by the imputed number of gross square feet per bed. The imputed number of gross square feet per bed shall be 461 for facilities of 90 or fewer beds, and 438 for facilities of more than 90 beds. The number of licensed nursing facility beds shall be the number on the last day of the provider's most recent fiscal year end for which a cost report has been filed.

"Factor for land and soft costs" means a factor equaling 1.429 that adjusts the construction cost amount to recognize land and capitalized costs associated with construction of a facility that are not part of the R.S. Means construction cost amount.

"Fixed capital replacement value" means an amount equal to the R.S. Means 75th percentile nursing home construction cost per square foot, times the applicable R.S. Means historical cost index factor, times the factor for land and soft costs, times the applicable R.S. Means "Location Factor," times facility imputed gross square feet.

"FRV depreciation rate" means a depreciation rate equal to 2.86% per year.

"Hospital-based facility" means one for which a single combined Medicare cost report is filed that includes the costs of both the hospital and the nursing home.

"Movable capital replacement value" means a value equal to $3,475 per bed in SFY 2001, and shall be increased each July 1 by the same R.S. Means historical cost index factor that is used to calculate the fixed capital replacement value. Each year's updated movable capital replacement value shall be used in the calculation of each provider's rate for the provider year beginning on or after the date the new value becomes effective.

"R.S.Means 75th percentile nursing construction cost per square foot" means the 75th percentile value published in the 59th Annual Edition of the R.S. Means Building Construction

Cost Data, 2001. In the 2000 edition of the R.S. Means publication this value is $110, which is reported as a January 2000 value.

"R.S.Means historical cost index factor" means the ratio of the two most recent R.S. Means Historical Cost Indexes published in the 59th Annual Edition of the R.S. Means Building Construction Cost Data, 2001. In the 2000 edition of this R.S. Means publication these two values are 117.6 (for 1999) and 115.1 (for 1998). The ratio of these values, and therefore the factor to be used, would be 1.022. This factor would be used to adjust the January 2000 value for the one year of change from January 2000 to January 2001, the mid-point of the prospective rate year (SFY 2001). The resulting cost value that would be used in SFY 2001 is $112.42. The indexes used in this calculation do not match the time period for which a factor is needed. They relate to 1998 and 1999, while 2000 and 2001 would be ideal. However, R.S. Means does not publish index forecasts, so the most recent available indexes shall be used.

"R.S. Means Location Factors" means those published in the 22nd Annual Edition of the R.S. Means Square Foot Costs, 2001. The 2000 location factors are shown in the following Table 1. They will be updated annually and distributed to providers based upon the most recent available data.

TABLE 1.
R.S. MEANS COMMERCIAL CONSTRUCTION COST LOCATION FACTORS (2000).

Zip Code	Principal City	Location Factor
220-221	Fairfax	0.90
222	Arlington	0.90
223	Alexandria	0.91
224-225	Fredericksburg	0.85
226	Winchester	0.80
227	Culpeper	0.80
228	Harrisonburg	0.77
229	Charlottesville	0.82
230-232	Richmond	0.85
233-235	Norfolk	0.82
236	Newport News	0.82
237	Portsmouth	0.81
238	Petersburg	0.84
239	Farmville	0.74
240-241	Roanoke	0.77
242	Bristol	0.75
243	Pulaski	0.70
244	Staunton	0.76
245	Lynchburg	0.77
246	Grundy	0.70

"Rental rate" means for a prospective year a rate equal to two percentage points plus the yield on U.S. Treasury Bonds with maturity over 10 years, averaged over the most recent three calendar years for which data are available, as published by the Federal Reserve (Federal Reserve Statistical Release H.15 Selected Interest Rates (www.Federalreserve.gov/releases/)). The rate will be published and distributed to providers annually. Changes in the rental rate shall be effective for the providers' fiscal year beginning on or after July 1. Rental rates may not fall below 9.0% or exceed 11% and will be updated annually on or about July 1 each year. Effective July 1, 2010, through September 30, 2010, the floor for the nursing facility rental rates may not fall below 8.75%. Effective October 1, 2010, through June 30, 2011, the floor for the nursing facility rental rates may not fall below 9.0%. Effective July 1, 2011, through June 30, 2012, the floor for the nursing facility rental rates may not fall below 8.0%. The rate will be published and distributed to providers annually. Changes in the rental rate shall be effective for the providers' fiscal year beginning on or after July 1.

"Required occupancy percentage" means an occupancy percentage of 90%.

"SFY" means State Fiscal Year (July 1 through June 30).

1. Fair Rental Value (FRV) Payment for Capital. Effective for dates of service on or after July 1, 2001, DMAS shall pay nursing facility capital related costs under a ~~Fair Rental Value (FRV)~~ FRV methodology. The payment made under this methodology shall be the only payment for capital related costs, and no separate payment shall be made for depreciation or interest expense, lease costs, property taxes, insurance, or any other capital related cost, including home office capital costs. This payment is considered to cover costs related to land, buildings and fixed equipment, major movable equipment, and any other capital related item. This shall be the case regardless of whether the property is owned or leased by the operator. The department shall review the operation and performance of the FRV methodology every two years.

2. FRV Rate Year. The FRV payment rate shall be a per diem rate determined each year for each facility using the most recent available data from settled cost reports, or from other verified sources as specified herein. The per diem rate shall be determined prospectively and shall apply for the entire fiscal year. Each provider shall receive a new capital per diem rate each year effective at the start of the provider's fiscal year, except that the capital per diem rate

shall be revised for the rental rate changes effective July 1, 2010, through June 30, 2012. Data elements that are provider specific shall be revised at that time and shall rely on the settled cost report and schedule of assets of the previous year. Data elements that are not provider specific, including those published by R.S. Means and the rental rate, shall be determined annually on or about July 1, and shall apply to provider fiscal years beginning on or after July 1. That is, each July 1 DMAS shall determine the R.S. Means values and the rental rate, and these shall apply to all provider fiscal years beginning on or after July 1.

12VAC30-90-41. Nursing facility reimbursement formula.

A. Effective on and after July 1, 2002, all NFs subject to the prospective payment system shall be reimbursed under "The Resource Utilization Group-III (RUG-III) System as defined in Appendix IV (12VAC30-90-305 through 12VAC30-90-307)." RUG-III is a resident classification system that groups NF residents according to resource utilization. Case-mix indices (CMIs) are assigned to RUG-III groups and are used to adjust the NF's per diem rates to reflect the intensity of services required by a NF's resident mix. See 12VAC30-90-305 through 12VAC30-90-307 for details on the Resource Utilization Groups.

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. Direct and indirect group ceilings and rates.

a. In accordance with 12VAC30-90-20 C, 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 12VAC30-90-271.

b. Indirect patient care operating cost peer groups shall be established for the Virginia portion of the Washington DC-MD-VA MSA, for the rest of the state for facilities with less than 61 licensed beds, and for the rest of the state for facilities with more than 60 licensed beds.

3. Each facility's average case-mix index shall be calculated based upon data reported by that nursing facility to the Centers for Medicare and Medicaid Services (CMS) (formerly HCFA) Minimum Data Set (MDS) System. See 12VAC30-90-306 for the case-mix index calculations.

4. The normalized facility average Medicaid CMI shall 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 NFs subsequent fiscal year. See 12VAC30-90-306 D 2 for the calculation of the normalized facility average Medicaid CMI.

a. A NFs direct patient care operating cost prospective ceiling shall be the product of the NFs peer group direct patient care ceiling and the NFs normalized facility average Medicaid CMI. A NFs direct patient care operating cost prospective ceiling will be calculated semiannually.

b. A CMI rate adjustment for each semiannual period of a nursing facility's prospective fiscal year shall be applied by multiplying the nursing facility's normalized facility average Medicaid CMI applicable to each prospective semiannual period by the nursing facility's case-mix neutralized direct patient care operating cost base rate for the preceding cost reporting period (see 12VAC30-90-307).

c. See 12VAC30-90-307 for the applicability of case-mix indices.

5. Direct and indirect ceiling calculations.

a. Effective for services on and after July 1, 2006, the direct patient care operating ceiling shall be set at 117% of the respective peer group day-weighted median of the facilities' case-mix neutralized direct care operating costs per day. The calculation of the medians shall be based on cost reports from freestanding nursing homes for provider fiscal years ending in the most recent base year. The medians used to set the peer group direct patient care operating ceilings shall be revised and case-mix neutralized every two years using the most recent reliable calendar year cost settled cost reports for freestanding nursing facilities that have been completed as of September 1.

b. The indirect patient care operating ceiling shall be set at 107% of the respective peer group day-weighted median of the facility's specific indirect operating cost per day. The calculation of the peer group medians shall be based on cost reports from freestanding nursing homes for provider fiscal years ending in the most recent base year. The medians used to set the peer group indirect operating ceilings shall be revised every two years using the most recent reliable calendar year cost settled cost reports for freestanding nursing facilities that have been completed as of September 1.

6. Reimbursement for use of specialized treatment beds. Effective for services on and after July 1, 2005, nursing facilities shall be reimbursed an additional $10 per day for those recipients who require a specialized treatment bed due to their having at least one Stage IV pressure ulcer. Recipients must meet criteria as outlined in 12VAC30-60-350, and the additional reimbursement must be preauthorized as provided in 12VAC30-60-40. Nursing facilities shall not be eligible to receive this reimbursement

for individuals whose services are reimbursed under the specialized care methodology. Beginning July 1, 2005, this additional reimbursement shall be subject to adjustment for inflation in accordance with 12VAC30-90-41 B, except that the adjustment shall be made at the beginning of each state fiscal year, using the inflation factor that applies to provider years beginning at that time. This additional payment shall not be subject to direct or indirect ceilings and shall not be adjusted at year-end settlement.

B. Adjustment of ceilings and costs for inflation. Effective for provider fiscal years starting on and after July 1, 2002, ceilings and rates shall be adjusted for inflation each year using the moving average of the percentage change of the Virginia-Specific Nursing Home Input Price Index, updated quarterly, published by Standard & Poor's DRI. For state fiscal year 2003, peer group ceilings and rates for indirect costs will not be adjusted for inflation.

1. For provider years beginning in each calendar year, the percentage used shall be the moving average for the second quarter of the year, taken from the table published for the fourth quarter of the previous year. For example, in setting prospective rates for all provider years beginning in January through December 2002, ceilings and costs would be inflated using the moving average for the second quarter of 2002, taken from the table published for the fourth quarter of 2001.

2. Provider specific costs shall be adjusted for inflation each year from the cost reporting period to the prospective rate period using the moving average as specified in subdivision 1 of this subsection. If the cost reporting period or the prospective rate period is less than 12 months long, a fraction of the moving average shall be used that is equal to the fraction of a year from the midpoint of the cost reporting period to the midpoint of the prospective rate period.

3. Ceilings shall be adjusted from the common point established in the most recent rebasing calculation. Base period costs shall be adjusted to this common point using moving averages from the DRI tables corresponding to the provider fiscal period, as specified in subdivision 1 of this subsection. Ceilings shall then be adjusted from the common point to the prospective rate period using the moving average(s) for each applicable second quarter, taken from the DRI table published for the fourth quarter of the year immediately preceding the calendar year in which the prospective rate years begin. Rebased ceilings shall be effective on July 1 of each rebasing year, so in their first application they shall be adjusted to the midpoint of the provider fiscal year then in progress or then beginning. Subsequently, they shall be adjusted each year from the common point established in rebasing to the midpoint of the appropriate provider fiscal year. For example, suppose the base year is made up of cost reports from years ending in calendar year 2000, the rebasing year is SFY2003, and the rebasing calculation establishes ceilings that are inflated to the common point of July 1, 2002. Providers with years in progress on July 1, 2002, would receive a ceiling effective July 1, 2002, that would be adjusted to the midpoint of the provider year then in progress. In some cases this would mean the ceiling would be reduced from the July 1, 2002, ceiling level. The following table shows the application of these provisions for different provider fiscal periods.

Table I
Application of Inflation to Different Provider Fiscal Periods

Provider FYE	Effective Date of New Ceiling	First PFYE After Rebasing Date	Inflation Time Span from Ceiling Date to Midpoint of First PFY	Second PFYE After Rebasing Date	Inflation Time Span from Ceiling Date to Midpoint of Second PFY
3/31	7/1/02	3/31/03	+ 1/4 year	3/31/04	+ 1-1/4 years
6/30	7/1/02	6/30/03	+ 1/2 year	6/30/04	+ 1-1/2 years
9/30	7/1/02	9/30/02	- 1/4 year	9/30/03	+ 3/4 year
12/31	7/1/02	12/31/02	-0-	12/31/03	+ 1 year

The following table shows the DRI tables that would provide the moving averages for adjusting ceilings for different prospective rate years.

Table II
Source Tables for DRI Moving Average Values

Provider FYE	Effective Date of New Ceiling	First PFYE After Rebasing Date	Source DRI Table for First PFY Ceiling Inflation	Second PFYE After Rebasing Date	Source DRI Table for Second PFY Ceiling Inflation
3/31	7/1/02	3/31/03	Fourth Quarter 2001	3/31/04	Fourth Quarter 2002
6/30	7/1/02	6/30/03	Fourth Quarter 2001	6/30/04	Fourth Quarter 2002
9/30	7/1/02	9/30/02	Fourth Quarter 2000	9/30/03	Fourth Quarter 2001
12/31	7/1/02	12/31/02	Fourth Quarter 2000	12/31/03	Fourth Quarter 2001

In this example, when ceilings are inflated for the second PFY after the rebasing date, the ceilings will be inflated from July 1, 2002, using moving averages from the DRI table specified for the second PFY. That is, the ceiling for years ending June 30, 2004, will be the June 30, 2002, base period ceiling, adjusted by 1/2 of the moving average for the second quarter of 2002, compounded with the moving average for the second quarter of 2003. Both these moving averages will be taken from the fourth quarter 2002 DRI table.

C. The RUG-III Nursing Home Payment System shall 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 rate or prospective operating ceiling.

D. Nonoperating costs. Plant or capital, as appropriate, costs shall be reimbursed in accordance with Articles 1, 2, and 3 of this subpart. Plant costs shall not include the component of cost related to making or producing a supply or service.

NATCEPs cost shall be reimbursed in accordance with 12VAC30-90-170.

E. The prospective rate for each NF shall be based upon operating cost and plant/capital 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 or capital, as appropriate, costs and NATCEPs costs shall be reflected in the year in which the nonreimbursable costs are included.

F. Effective July 1, 2001, for those NFs whose indirect 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 indirect operating cost rates and the indirect peer group ceilings.

1. The following table presents four incentive examples:

Peer Group Ceilings	Allowable Cost Per Day	Difference	% of Ceiling	Sliding Scale	Scale % Difference
$30.00	$27.00	$3.00	10%	$0.30	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. Efficiency incentives shall be calculated only for the indirect patient care operating ceilings and costs. Effective July 1, 2001, a direct care efficiency incentive shall no longer be paid.

G. Quality of care requirement. A cost efficiency incentive shall not be paid for the number of days for which a facility is out of substantial compliance according to the Virginia Department of Health survey findings as based on federal regulations.

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.

J. Effective July 1, 2005, the total per diem payment to each nursing home shall be increased by $3.00 per day. This increase in the total per diem payment shall cease effective July 1, 2006. Effective July 1, 2006, when cost data that include time periods before July 1, 2005, are used to set facility specific rates, a portion of the $3.00 per day amount identified above, based on the percentage of patient days in the provider's cost reporting period that fall before July 1, 2005, adjusted for appropriate inflation and multiplied times the provider's Medicaid utilization rate, shall be allocated to the facility specific direct and indirect cost per day prior to

comparison to the peer group ceilings. For purposes of this subsection, $1.68 of the $3.00 shall be considered direct costs and $1.32 of the $3.00 shall be considered indirect costs.

K. Effective July 1, 2008, and ending after June 30, 2009, the operating rate for nursing facilities shall be reduced by 1.329%.

L. Effective July 1, 2009, through June 30, 2010, there will be no inflation adjustment for nursing facility operating rates and ceilings and specialized care operating rates and ceilings. Exempt from this are government-owned nursing facilities with Medicaid utilization of 85% or greater in provider fiscal year 2007.

M. Effective July 1, 2010, through June 30, 2012, there shall be no inflation adjustment for nursing facility and specialized care operating rates. Nursing facility and specialized care ceilings shall freeze at the same level as the ceilings for nursing facilities with provider fiscal year ends of June 30, 2010.

N. Effective July 1, 2010, through September 30, 2010, the operating rate for nursing facilities shall be reduced 3.0% below the rates otherwise calculated.

VA.R. Doc. No. R11-2785; Filed May 6, 2011, 9:23 a.m.

Final Regulation

REGISTRAR'S NOTICE: The Department of Medical Assistance Services is claiming an exemption from the Administrative Process Act in accordance with § 2.2-4006 A 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 from any interested person at any time with respect to reconsideration or revision.

Title of Regulation: **12VAC30-80. Methods and Standards for Establishing Payment Rates; Other Types of Care (amending 12VAC30-80-40).**

Statutory Authority: §§ 32.1-324 and 32.1-325 of the Code of Virginia.

Effective Date: July 1, 2011.

Agency Contact: Scott Cannady, Program Operations, Pharmacy Section, Department of Medical Assistance Services, 600 East Broad Street, Richmond, VA 23219, telephone (804) 786-7959, FAX (804) 786-1680, or email scott.cannady@dmas.virginia.gov.

Summary:

This regulatory action amends 12VAC30-80-40 for the estimated acquisition cost payment methodology for Medicaid fee-for-service pharmacy services to reinstitute average wholesale price (AWP) minus 13.1% as a permanent methodology. This modification is required to comply with Item 297 SSS of the 2011 Appropriation Act, which requires DMAS to remove the temporary status language of the prior AWP minus 13.1% reduction effective July 1, 2011.

12VAC30-80-40. Fee-for-service providers: pharmacy.

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 447.512(c) if the brand cost is greater than the Centers for Medicare and Medicaid Services (CMS) upper limit of VMAC cost) subject to the conditions, where applicable, set forth in subdivisions 6 and 7 of this section:

1. The upper limit established by the CMS for multiple source drugs pursuant to 42 CFR 447.512 and 447.514, as determined by the CMS Upper Limit List plus a dispensing fee. If the agency provides payment for any drugs on the HCFA Upper Limit List, the payment shall be subject to the aggregate upper limit payment test.

2. The methodology used to reimburse for generic drug products shall be the higher of either (i) the lowest Wholesale Acquisition Cost (WAC) plus 10% or (ii) the second lowest WAC plus 6.0%. This methodology shall reimburse for products' costs based on a Maximum Allowable Cost (VMAC) list to be established by the single state agency.

a. In developing the maximum allowable reimbursement rate for generic pharmaceuticals, the department or its designated contractor shall:

(1) Identify three different suppliers, including manufacturers that are able to supply pharmaceutical products in sufficient quantities. The drugs considered must be listed as therapeutically and pharmaceutically equivalent in the Food and Drug Administration's most recent version of the Approved Drug Products with Therapeutic Equivalence Evaluations (Orange Book). Pharmaceutical products that are not available from three different suppliers, including manufacturers, shall not be subject to the VMAC list.

(2) Identify that the use of a VMAC rate is lower than the Federal Upper Limit (FUL) for the drug. The FUL is a known, widely published price provided by CMS; and

(3) Distribute the list of state VMAC rates to pharmacy providers in a timely manner prior to the implementation of VMAC rates and subsequent modifications. DMAS shall publish on its website, each month, the information used to set the Commonwealth's prospective VMAC rates, including, but not necessarily limited to:

(a) The identity of applicable reference products used to set the VMAC rates;

(b) The Generic Code Number (GCN) or National Drug Code (NDC), as may be appropriate, of reference products;

(c) The difference by which the VMAC rate exceeds the appropriate WAC price; and

(d) The identity and date of the published compendia used to determine reference products and set the VMAC rate. The difference by which the VMAC rate exceeds the appropriate WAC price shall be at least or equal to 10% above the lowest-published wholesale acquisition cost for products widely available for purchase in the Commonwealth and shall be included in national pricing compendia.

b. Development of a VMAC rate that does not have a FUL rate shall not result in the use of higher-cost innovator brand name or single source drugs in the Medicaid program.

c. DMAS or its designated contractor shall:

(1) Implement and maintain a procedure to add or eliminate products from the list, or modify VMAC rates, consistent with changes in the fluctuating marketplace. DMAS or its designated contractor will regularly review manufacturers' pricing and monitor drug availability in the marketplace to determine the inclusion or exclusion of drugs on the VMAC list; and

(2) Provide a pricing dispute resolution procedure to allow a dispensing provider to contest a listed VMAC rate. DMAS or its designated contractor shall confirm receipt of pricing disputes within 24 hours, via telephone or facsimile, with the appropriate documentation of relevant information, e.g., invoices. Disputes shall be resolved within three business days of confirmation. The pricing dispute resolution process will include DMAS' or the contractor's verification of accurate pricing to ensure consistency with marketplace pricing and drug availability. Providers will be reimbursed, as appropriate, based on findings. Providers shall be required to use this dispute resolution process prior to exercising any applicable appeal rights.

3. The provider's usual and customary charge to the public, as identified by the claim charge.

4. The Estimated Acquisition Cost (EAC), which shall be based on the published Average Wholesale Price (AWP) minus a percentage discount established by the General Assembly (as set forth in subdivision ~~8~~ 7 of this section) or, in the absence thereof, by the following methodology set out in subdivisions a through c of this subdivision.

a. Percentage discount shall be determined by a statewide survey of providers' acquisition cost.

b. The survey shall reflect statistical analysis of actual provider purchase invoices.

c. The agency will conduct surveys at intervals deemed necessary by DMAS.

5. MAC methodology for specialty drugs. Payment for drug products designated by DMAS as specialty drugs shall be the lesser of subdivisions 1 through 4 of this section or the following method, whichever is least:

a. The methodology used to reimburse for designated specialty drug products shall be the WAC price plus the WAC percentage. The WAC percentage is a constant percentage identified each year for all GCNs.

b. Designated specialty drug products are certain products used to treat chronic, high-cost, or rare diseases; the drugs subject to this pricing methodology and their current reimbursement rates are listed on the DMAS website at the following internet address: http://www.dmas.virginia.gov/downloads/pdfs/pharm-special_mac_list.pdf.

c. The MAC reimbursement methodology for specialty drugs shall be subject to the pricing review and dispute resolution procedures described in subdivisions 2 c (1) and 2 c (2) of this section.

6. Payment for pharmacy services will be as described above; however, payment for legend drugs will include the allowed cost of the drug plus only one dispensing fee per month for each specific drug. Exceptions to the monthly dispensing fees shall be allowed for drugs determined by the department to have unique dispensing requirements. The dispensing fee for brand name and generic drugs is $3.75.

7. The Program pays additional reimbursement for unit dose dispensing systems of dispensing drugs. DMAS defines its unit dose dispensing system coverage consistent with that of the Board of Pharmacy of the Department of Health Professions (18VAC110-20-420). This service is paid only for patients residing in nursing facilities. Reimbursements are based on the allowed payments described above plus the unit dose per capita fee to be calculated by DMAS' fiscal agent based on monthly per nursing home resident service per pharmacy provider. Only one service fee per month may be paid to the pharmacy for each patient receiving unit dose dispensing services. Multisource drugs will be reimbursed at the maximum allowed drug cost for specific multiple source drugs as identified by the state agency or CMS' upper limits as applicable. All other drugs will be reimbursed at drug costs not to exceed the estimated acquisition cost determined by the state agency. The original per capita fee shall be determined by a DMAS analysis of costs related to such dispensing, and shall be reevaluated at periodic intervals

for appropriate adjustment. The unit dose dispensing fee is $5.00 per recipient per month per pharmacy provider.

~~8.~~ An EAC of AWP minus 13.1% shall become effective July 1, ~~2010, through September 30, 2010. An EAC of AWP minus 10.25% shall become effective October 1, 2010~~ 2011. The dispensing fee for brand name and generic drugs of $3.75 shall remain in effect, creating a payment methodology based on the previous algorithm (least of subdivisions of this section) plus a dispensing fee where applicable.

~~9.~~ 8. Home infusion therapy.

a. The following therapy categories shall have a pharmacy service day rate payment allowable: hydration therapy, chemotherapy, pain management therapy, drug therapy, total parenteral nutrition (TPN). The service day rate payment for the pharmacy component shall apply to the basic components and services intrinsic to the therapy category. Submission of claims for the per diem rate shall be accomplished by use of the CMS 1500 claim form.

b. The cost of the active ingredient or ingredients for chemotherapy, pain management and drug therapies shall be submitted as a separate claim through the pharmacy program, using standard pharmacy format. Payment for this component shall be consistent with the current reimbursement for pharmacy services. Multiple applications of the same therapy shall be reimbursed one service day rate for the pharmacy services. Multiple applications of different therapies shall be reimbursed at 100% of standard pharmacy reimbursement for each active ingredient.

~~10.~~ 9. Supplemental rebate agreement. Based on the requirements in § 1927 of the Social Security Act, the Commonwealth of Virginia has the following policies for the supplemental drug rebate program for Medicaid recipients:

a. The model supplemental rebate agreement between the Commonwealth and pharmaceutical manufacturers for legend drugs provided to Medicaid recipients, submitted to CMS on February 5, 2004, and entitled Virginia Supplemental Drug Rebate Agreement Contract A and Amendment #2 to Contract A has been authorized by CMS.

b. The model supplemental rebate agreement between the Commonwealth and pharmaceutical manufacturers for drugs provided to Medicaid recipients, submitted to CMS on February 5, 2004, and entitled Virginia Supplemental Drug Rebate Agreement Contract B and Amendment #2 to Contract B has been authorized by CMS.

c. The model supplemental rebate agreement between the Commonwealth and pharmaceutical manufacturers for drugs provided to Medicaid recipients, submitted to CMS on February 5, 2004, and entitled Virginia Supplemental Drug Rebate Agreement Contract C, and Amendments #1 and #2 to Contract C has been authorized by CMS.

d. Supplemental drug rebates received by the state in excess of those required under the national drug rebate agreement will be shared with the federal government on the same percentage basis as applied under the national drug rebate agreement.

e. Prior authorization requirements found in § 1927(d)(5) of the Social Security Act have been met.

f. Nonpreferred drugs are those that were reviewed by the Pharmacy and Therapeutics Committee and not included on the preferred drug list. Nonpreferred drugs will be made available to Medicaid beneficiaries through prior authorization.

g. Payment of supplemental rebates may result in a product's inclusion on the PDL.

VA.R. Doc. No. R11-2780; Filed May 6, 2011, 9:22 a.m.

Final Regulation

REGISTRAR'S NOTICE: The Department of Medical Assistance Services is claiming an exemption from the Administrative Process Act in accordance with § 2.2-4006 A 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 from any interested person at any time with respect to reconsideration or revision.

Titles of Regulations: **12VAC30-120. Waivered Services (amending 12VAC30-120-165, 12VAC30-120-180, 12VAC30-120-190, 12VAC30-120-225, 12VAC30-120-233, 12VAC30-120-766, 12VAC30-120-950, 12VAC30-120-960, 12VAC30-120-980).**

12VAC30-135. Demonstration Waiver Services (amending 12VAC30-135-200, 12VAC30-135-220).

Statutory Authority: §§ 32.1-324 and 32.1-325 of the Code of Virginia.

Effective Date: July 1, 2011.

Agency Contact: Brian McCormick, Regulatory Supervisor, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-8856, FAX (804) 786-1680, or email brian.mccormick@dmas.virginia.gov.

Summary:

The amendments conform 12VAC30-120, Waivered Services (for home and community based programs), and 12VAC30-135, Demonstration Waiver Services, (for the children's mental health waiver) to Item 297 WW and

CCCCC of the 2011 Appropriation Act, which imposed new limits for respite services and personal care services. Respite services are limited to 480 hours covered annually and personal care services are limited to 56 hours per waiver individual per week, up to 52 weeks per year. Individual exceptions to the personal care services limitation may be granted based on criteria established by the Department of Medical Assistance Services.

12VAC30-120-165. Consumer-directed services: personal assistance and respite care services.

A. Service definition.

1. Consumer-directed personal assistance services are care of either a supportive or health-related nature and may include, but are not limited to, assistance with activities of daily living, access to the community, monitoring of self-administration of medication or other medical needs, monitoring health status and physical condition, and work-related personal assistance. When specified on the plan of care, such supportive services may include assistance with instrumental activities of daily living (IADLs). Personal assistance does not include either practical or professional nursing services or those practices regulated in Chapters 30 (§ 54.1-3000 et seq.) and 34 (§ 54.1-3400 et seq.) of Subtitle III of Title 54.1 of the Code of Virginia, as appropriate.

2. Consumer-directed respite care services are specifically designed to provide temporary, periodic, or routine relief to the unpaid primary caregiver of an individual. Respite services include, but are not limited to, assistance with personal hygiene, nutritional support, and environmental support. This service may be provided in the individual's home or other community settings.

3. DMAS shall either provide for fiscal agent services or contract for the services of a fiscal agent for consumer-directed personal assistance services and consumer-directed respite care services. The fiscal agent will be reimbursed by DMAS (if the service is contracted) to perform certain tasks as an agent for the individual/employer who is receiving consumer-directed services. The fiscal agent will handle responsibilities for the individual for employment taxes. The fiscal agent will seek and obtain all necessary authorizations and approvals of the Internal Revenue Service in order to fulfill all of these duties.

4. Individuals choosing consumer-directed services must receive support from a CD services facilitator. This is not a separate waiver service, but is required in conjunction with consumer-directed personal assistance services or consumer-directed respite care services. The CD service facilitator is responsible for assessing the individual's particular needs for a requested CD service, assisting in the development of the plan of care, providing training to the individual and family/caregiver on his responsibilities as an employer, and providing ongoing support of the consumer-directed services.

B. Criteria.

1. In order to qualify for consumer-directed personal assistance services, the individual must demonstrate a need for personal assistance in activities of daily living, community access, self-administration of medication or other medical needs, or monitoring health status or physical condition.

2. Consumer-directed respite care services may only be offered to individuals who have an unpaid primary caregiver living in the home who requires temporary relief to avoid institutionalization of the individual. Respite services are designed to focus on the need of the unpaid caregiver for temporary relief and to help prevent the breakdown of the unpaid caregiver due to the physical burden and emotional stress of providing continuous support and care to the individual.

3. Individuals who are eligible for consumer-directed services must have the capability to hire and train their own personal assistants and supervise the assistant's performance or, if an individual is unable to direct his own care or is under 18 years of age, a family/caregiver may serve as the employer on behalf of the individual.

4. The individual, or if the individual is unable, then a family/caregiver, shall be the employer of consumer-directed services, and therefore shall be responsible for hiring, training, supervising, and firing assistants. Specific employer duties include checking of references of personal assistants, determining that personal assistants meet basic qualifications, training assistants, supervising the assistant's performance, and submitting timesheets to the fiscal agent on a consistent and timely basis. The individual or family/caregiver must have a back-up plan for the provision of services in case the assistant does not show up for work as expected or terminates employment without prior notice.

5. Assistants may not be the parents of individuals who are minors or the individuals' spouses. Payment may not be made for services furnished by other family/caregivers living under the same roof as the individual being served unless there is objective written documentation as to why there are no other providers available to provide the care.

C. Service units and service limitations.

1. The unit of service for consumer-directed respite services is one hour. Effective July 1, 2011, ~~Consumer-directed~~ consumer-directed respite services are limited to a maximum of ~~720~~ 480 hours per ~~calendar~~ year. Individuals who receive either consumer-directed respite care or agency-directed respite care services, or both, may not

receive more than ~~720~~ 480 hours combined in a ~~calendar~~ year.

2. No more than two unrelated individuals who live in the same home are permitted to share the authorized work hours of the personal assistant.

3. The unit of service for consumer-directed personal assistance services is one hour. Effective July 1, 2011, consumer-directed personal assistance services shall be limited to 56 hours of medically necessary services per week for 52 weeks per year. Individual exceptions may be granted based on criteria established by DMAS.

D. Provider qualifications. In addition to meeting the general conditions and requirements for home and community-based services, participating providers as specified in 12VAC30-120-150 and 12VAC30-120-160, the CD services facilitator must meet the following qualifications:

1. To be enrolled as a Medicaid CD services facilitator and maintain provider status, the CD services facilitator must have sufficient resources to perform the required activities. In addition, the CD services facilitator must have the ability to maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the services provided.

2. It is preferred that the CD services facilitator possess a minimum of an undergraduate degree in a human services field or be a registered nurse currently licensed to practice in the Commonwealth of Virginia. The CD services facilitator must possess a combination of work experience and relevant education that indicates possession of the following knowledge, skills, and abilities. Such knowledge, skills, and abilities must be documented on the provider's application form, found in supporting documentation, or be observed during the job interview. Observations of knowledge, skills, and abilities demonstrated during the interview must be documented. The knowledge, skills, and abilities include:

a. Knowledge of:

(1) Types of functional limitations and health problems that may occur in persons with HIV/AIDS, as well as strategies to reduce limitations and health problems;

(2) Physical assistance that may be required by persons with HIV/AIDS, such as transferring, bathing techniques, bowel and bladder care, and the approximate time those activities normally take;

(3) Equipment and environmental modifications that may be required by persons with HIV/AIDS that reduce the need for human help and improve safety;

(4) Various long-term care program requirements, including nursing facility and assisted living facility placement criteria; Medicaid waiver services; and other federal, state and local resources that provide personal assistance and respite care services;

(5) DMAS HIV/AIDS waiver requirements, as well as the administrative duties for which the recipient will be responsible;

(6) Conducting assessments (including environmental, psychosocial, health, and functional factors) and their uses in care planning;

(7) Interviewing techniques;

(8) The individual's right to make decisions about, direct the provisions of, and control his CD personal assistance and respite services, including hiring, training, managing, approving time sheets, and firing an assistant;

(9) The principles of human behavior and interpersonal relationships; and

(10) General principles of record documentation.

b. Skills in:

(1) Negotiating with individuals and service providers;

(2) Assessing, supporting, observing, recording, and reporting behaviors;

(3) Identifying, developing, or providing services to individuals with HIV/AIDS; and

(4) Identifying services within the established services system to meet the individual's needs.

c. Abilities to:

(1) Report findings of the assessment or onsite visit, either in writing or an alternative format for individuals who have visual impairments;

(2) Demonstrate a positive regard for individuals and their families;

(3) Be persistent and remain objective;

(4) Work independently, performing position duties under general supervision;

(5) Communicate effectively, verbally and in writing; and

(6) Develop a rapport and communicate with different types of individuals from diverse cultural backgrounds.

3. If the CD services facilitator is not a registered nurse, the service facilitator must inform the primary health care provider that CD services are being provided and to request consultation as needed.

E. Service facilitator responsibilities.

1. The CD service facilitator shall maintain a personal assistant registry. The registry shall contain names of persons who have experience with providing personal

assistance services or who are interested in providing personal assistance services. The registry shall be maintained as a supportive source for the individual who may use the registry to obtain the names of potential personal assistants. The CD service facilitator shall note on the plan of care what constitutes the individual's back-up plan in case the personal assistant does not report for work as expected or terminates employment without prior notice.

2. Upon the individual's request, the CD service facilitator shall provide the individual with a list of persons on the personal assistant registry who can provide temporary assistance until the assistant returns or the individual is able to select and hire a new personal assistant. If an individual is consistently unable to hire and retain the employment of an assistant to provide personal assistance services, the CD service facilitator must make arrangements with the case manager to have the services transferred to an agency-directed services provider or to discuss with the individual or family/caregiver other service options.

3. For consumer-directed services, the CD services facilitator must make an initial comprehensive home visit to collaborate with the individual and family/caregiver to identify the needs, assist in the development of the plan of care with the individual or family/caregiver, and provide employee management training. Individuals or family/caregivers who cannot receive management training at the time of the initial visit must receive management training within seven days of the initial visit. The initial comprehensive home visit is done only once upon the individual's entry into the service. If a waiver individual changes CD services facilitators, the new CD services facilitator must complete a reassessment visit in lieu of a comprehensive visit.

4. After the initial visit, two routine onsite visits must occur in the individual's home within 60 days of the initiation of care or the initial visit to monitor the plan of care. The first onsite visit shall occur within 30 days and the second onsite visit shall occur no later than 30 days after the first onsite visit. The CD service facilitator will continue to monitor the plan of care on an as needed basis, not to exceed a maximum of one routine onsite visit every 30 days but no less than the minimum of one routine onsite visit every 90 days per individual. If additional onsite visits are required, the provider must have documentation to show the necessity for these extra visits. After the first two routine onsite visits, the CD services facilitator and individual can decide on the frequency of the routine onsite visits.

5. After the initial visit, the CD services facilitator will continue to monitor the assistant's plan of care quarterly and on an as-needed basis. The CD services facilitator will review the utilization of consumer-directed respite services, either every six months or upon the use of 300 respite services hours, whichever comes first.

6. A face-to-face meeting with the individual must be conducted at least every 90 days to ensure appropriateness of any CD services received by the individual.

7. During visits with the individual, the CD services facilitator must observe, evaluate, and consult with the individual or family/caregiver, and document the adequacy and appropriateness of consumer-directed services with regard to the individual's current functioning and cognitive status, medical, and social needs. The CD services facilitator's written summary of the visit must include, but is not necessarily limited to:

a. Discussion with the individual or family/caregiver whether the service is adequate to meet the individual's needs;

b. Any suspected abuse, neglect, or exploitation and who it was reported to;

c. Any special tasks performed by the assistant and the assistant's qualifications to perform these tasks;

d. Individual's or family/caregiver's satisfaction with the service;

e. Any hospitalization or change in medical condition, functioning, or cognitive status;

f. The presence or absence of the assistant in the home during the CD services facilitator's visit; and

g. Other services received and the amount.

8. The CD services facilitator must be available to the individual by telephone.

9. Prior to a personal assistant providing services, the CD services facilitator must submit a criminal record check pertaining to the assistant on behalf of the individual and report findings of the criminal record check to the individual or the family/caregiver and the fiscal agent. If the individual is a minor, the assistant must also be screened through the DSS Child Protective Services Central Registry. Personal assistants will not be reimbursed for services provided to the individual on or after the date that the criminal record check confirms an assistant has been found to have been convicted of a crime as described in § 32.1-162.9:1 of the Code of Virginia or if the personal assistant has a confirmed record on the DSS Child Protective Services Registry. DMAS will reimburse for up to six criminal record checks per individual within a six-month period.

10. The CD services facilitator, during routine visits, shall verify bi-weekly timesheets signed by the individual or the family/caregiver and the personal assistant to ensure that the number of plan of care approved hours are not

exceeded. If discrepancies are identified, the CD services facilitator must contact the individual to resolve the discrepancies and must notify the fiscal agent. If an individual is consistently being identified as having discrepancies in his timesheets, the CD services facilitator must contact the case manager to resolve the situation. The CD services facilitator shall not verify timesheets for personal assistants whose criminal record checks have confirmed that they have been convicted of a crime described in § 32.1-162.9:1 of the Code of Virginia or in the case of a minor recipient have a confirmed case with the DSS Child Protective Services Registry and must notify the fiscal agent.

11. The CD services facilitator must maintain records of each individual. At a minimum these records must contain:

a. All copies of the completed Uniform Assessment Instrument (UAI), all documentation of previous inpatient hospital admissions, the Long-Term Care Preadmission Screening Authorization (DMAS-96), the Screening Team Service Plan (DMAS-97), the Consent to Exchange Information (DMAS-20), all Consumer-Directed Personal Assistance Plans of Care (DMAS-97B), all Patient Information Forms (DMAS-122), the Outline and Checklist for Consumer-Directed Recipient Comprehensive Training, and the Service Agreement Between the Consumer and the Service Facilitator;

b. Reassessments made during the provision of services;

c. All individual progress reports;

d. Results of the initial comprehensive home visit completed prior to or on the date services are initiated and subsequent reassessments and changes to the supporting documentation;

e. The plan of care goals and activities must be reviewed at least annually by the CD services facilitator, the individual and family/caregiver receiving the services, and the case manager. In addition, the plan of care must be reviewed by the CD services facilitator quarterly, modified as appropriate, and submitted to the case manager;

f. CD service facilitator's dated notes documenting any contacts with the individual, family/caregiver, and visits to the individual's home;

g. All correspondence to the individual, case manager, the designated preauthorization contractor, and DMAS;

h. Records of contacts made with family/caregiver, physicians, formal and informal service providers, and all professionals concerning the individual;

i. All training provided to the assistants on behalf of the individual or family/caregiver;

j. All employee management training provided to the individual or family/caregiver, including the individual's or family/caregiver's receipt of training on their responsibility for the accuracy of the assistant's timesheets;

k. All documents signed by the individual or the individual's family/caregiver that acknowledge the responsibilities as the employer; and

l. Documentation that indicates the efforts taken by the CD service facilitator to obtain the most recently completed DMAS-122 from the case manager.

12. The CD service facilitator is required to submit to DMAS biannually, for every individual, an individual progress report, an updated UAI, documentation of any inpatient hospital admissions, and any monthly visit/progress reports. This information is used to assess the individual's ongoing need for Medicaid-funded long-term care and appropriateness and adequacy of services rendered.

13. For consumer-directed personal assistance and consumer-directed respite services, individuals or family/caregivers will hire their own personal assistants and manage and supervise their performance. Assistant qualifications include, but shall not necessarily be limited to, the following requirements. The assistant must:

a. Be 18 years of age or older;

b. Have the required skills to perform consumer-directed services as specified in the individual's plan of care;

c. Possess basic math, reading, and writing skills;

d. Possess a valid Social Security number;

e. Submit to a criminal records check and, if the individual is a minor, consent to a search of the DSS Child Protective Services Central Registry. The assistant will not be compensated for services provided to the individual if either of these records checks verifies the assistant has been convicted of crimes described in § 32.1-162.9:1 of the Code of Virginia or if the assistant has a founded complaint confirmed by the DSS Child Protective Services Central Registry;

f. Be willing to attend training at the individual's or family/ caregiver's request;

g. Understand and agree to comply with the DMAS AIDS waiver requirements;

h. Be willing to register in a personal assistant registry, which will be maintained by the provider agency chosen by the individual; and

i. Receive yearly tuberculosis (TB) screening, cardiopulmonary resuscitation (CPR) training and an

annual flu shot (unless these procedures are medically contraindicated).

14. Family members who are reimbursed to provide consumer-directed services must meet the assistant qualifications.

F. Individual responsibilities.

1. The individual must be authorized for consumer-directed services and successfully complete management training performed by the service facilitator before the individual can hire a personal assistant for Medicaid reimbursement. Individuals who are eligible for consumer-directed services must have the capability to hire and train their own personal assistants and supervise assistants' performance. Individuals with cognitive impairments will not be able to manage their own care. If an individual is unable to direct his own care, a family caregiver may serve as the employer on behalf of the individual. Individuals are permitted to share hours for no more than two individuals living in the same home.

2. The individual or family/caregiver is the employer and is responsible for hiring, training, supervising, and firing personal assistants. Specific duties include checking references of personal assistants, determining that personal assistants meet basic qualifications, training personal assistants, supervising the personal assistant's performance, and submitting timesheets to the fiscal agent on a consistent and timely basis. The individual must have an emergency back-up plan in case the personal assistant does not show up for work as expected or terminates employment without prior notice.

3. The individual shall cooperate with the development of the plan of care with the service facilitator, who monitors the plan of care and provides supportive services to the individual. The individual shall also cooperate with the fiscal agent that handles fiscal responsibilities on behalf of the individual. Individuals who do not cooperate with the service facilitator or fiscal agent may be disenrolled from consumer-directed services and may be considered for enrollment in agency-directed services.

4. Individuals will acknowledge that they will not knowingly continue to accept consumer-directed personal assistance services when the services are no longer appropriate or necessary for their care needs and will inform the service facilitator. If consumer-directed services continue after services have been terminated by DMAS or the designated preauthorization contractor, the individual will be held liable for employee compensation.

5. The individual's right to make decisions about, direct the provisions of, and control his consumer-directed personal assistance care and consumer-directed respite care services, including hiring, training, managing, approving time sheets, and firing an assistant, shall be preserved.

G. Fiscal agent responsibilities.

1. DMAS may contract for the services of a fiscal agent for consumer-directed services. The fiscal agent will be reimbursed by DMAS to perform certain tasks as an agent for the recipient/employer who is receiving consumer-directed services. The fiscal agent will handle certain responsibilities for the individual, including but not limited to, employment taxes. The fiscal agent will seek and obtain all necessary authorizations and approvals of the Internal Revenue Service in order to fulfill all of these duties.

2. A fiscal agent may be a state agency or other organization, and will sign a contract with DMAS that defines the roles and tasks expected of the fiscal agent and DMAS and enroll as a provider of consumer-directed services. Roles and tasks that will be deemed for the fiscal agent in the contract will consist of, but not necessarily be limited to, the following:

a. The fiscal agent will file for and obtain employer agent status with the federal and state tax authorities;

b. Once the individual has been authorized to receive consumer-directed services, the fiscal agent will register the individual as an employer and provide assistance to the individual in completing forms required to obtain employer identification numbers from federal agencies, state agencies, and unemployment insurance agencies;

c. The fiscal agent will prepare and maintain original and file copies of all forms needed to comply with federal, state, and local tax payment of unemployment compensation insurance premiums, and all other reporting requirements of employers;

d. Upon receipt of the required completed forms from the individual, the fiscal agent will remit the required forms to the appropriate agency and maintain copies of the forms in the individual's file. The fiscal agent will return copies of all forms to the individual for the individual's permanent personnel records;

e. The fiscal agent will prepare all unemployment tax filings on behalf of the individual as an employer, and make all deposits of unemployment taxes withheld according to the appropriate schedule;

f. The fiscal agent will receive and verify that the assistant's biweekly timesheets do not exceed the maximum hours approved for the individual and will process the timesheets;

g. The fiscal agent will prepare and process the payroll for the individual's assistants, and make all appropriate deposits of income tax, FICA, and other withholdings according to federal and state regulations. Withholdings include, but are not limited to, all judgments, garnishments, tax levies, or any related holds on the

funds of the personal assistants as may be required by local, state, or federal law;

h. The fiscal agent will prepare payrolls for the individual's personal assistant according to approved time sheets and after making appropriate deductions and withholding deposits;

i. The fiscal agent will make payments on behalf of the individual for FICA (employer and employee shares), unemployment compensation taxes, and other payments and taxes required by applicable federal or state laws or regulations;

j. The fiscal agent will distribute biweekly payroll checks to the individual's personal assistants on behalf of the individuals;

k. The fiscal agent will maintain accurate payroll records by preparing and submitting to DMAS, at the time the fiscal agent bills DMAS for personal assistance services, an accurate accounting of all payments on personal assistants to whom payments for services were made, including a report of FICA payments for each covered assistant;

l. The fiscal agent will maintain such other records and information as DMAS may require, in the form and manner prescribed by DMAS;

m. The fiscal agent will generate W-2 forms for all personal assistants who meet statutory threshold amounts during the tax year;

n. The fiscal agent will establish a customer service mechanism in order to respond to calls from individuals and personal assistants regarding lost or late checks, or other questions regarding payments that are not related to the authorization amounts generated from DMAS;

o. The fiscal agent will keep abreast of all applicable state and federal laws and regulations relevant to the responsibilities it has undertaken with regard to these filings;

p. The fiscal agent will use program-designated billing forms or electronic billing to bill DMAS, if this service is contracted; and

q. The fiscal agent will be capable of requesting electronic transfer of funds from DMAS.

3. The fiscal agent and all subcontracting bookkeeping firms, as appropriate, will maintain the confidentiality of Medicaid information in accordance with the following:

a. The fiscal agent agrees to comply with HIPAA requirements. The fiscal agent shall take measures to prudently safeguard and protect unauthorized disclosure of the Medicaid information in its possession. The fiscal agent shall establish internal policies to ensure compliance with federal and state laws and regulations regarding confidentiality. In no event shall the fiscal agent provide, grant, allow, or otherwise give access to Medicaid information to anyone without the express written permission of either the individual or the DMAS Director. The fiscal agent shall assume all liabilities under both state and federal law in the event that the information is disclosed in any manner.

b. Upon the fiscal agent receiving any written requests for Medicaid information from any individual, entity, corporation, partnership, or otherwise, the fiscal agent must notify DMAS of such requests within 24 hours of receipt of such requests. The fiscal agent shall ensure that there will be no disclosure of the data except by and through DMAS. DMAS will treat such requests in accordance with DMAS policies.

c. In cases where the information requested by outside sources can be released under the Freedom of Information Act (FOIA), as determined by DMAS, the fiscal agent shall provide support for copying and invoicing such documents.

4. A contract between the fiscal agent and the individual will be used to set forth those aspects of the employment relationship that are to be handled by the fiscal agent, and which are to be handled by the individual. The contract will reflect that the fiscal agent is performing these tasks on behalf of the individual who is the actual employer of the assistant. Before the individual begins receiving services, the fiscal agent must have a signed contract with the individual prior to the reimbursement of personal assistance services.

12VAC30-120-180. Agency-directed personal care services.

A. General. Agency-directed personal care services may be offered to waiver individuals. Personal care may be offered either as the sole home and community-based care service that avoids institutionalization or in conjunction with the other AIDS waiver services. Individuals may continue to work or attend post-secondary school, or both, while they receive services under this waiver. The personal care assistant who assists the individual may accompany the individual to work or school or both and may assist the individual with personal needs while the individual is at work or school or both. DMAS will also pay for any personal care services that the assistant gives to the individual to assist him in getting ready for work or school or both or when he returns home. DMAS or the designated preauthorization contractor will review the individual's needs and the complexity of the disability when determining the services that will be provided to the individual in the workplace or school or both.

1. Effective July 1, 2011, agency-directed personal care services shall be limited to 56 hours of medically necessary services per week for 52 weeks per year.

2. Individual exceptions may be granted based on criteria established by DMAS.

B. DMAS will not duplicate services that are required as a reasonable accommodation as a part of the Americans with Disabilities Act (ADA) (42 USC §§ 12131 through 12165) or the Rehabilitation Act of 1973. For example, if the individual's only need is for assistance during lunch, DMAS would not pay for the assistant to be with the individual for any hours extending beyond lunch. For an individual whose speech is such that he cannot be understood without an interpreter (not translation of a foreign language), or the individual is physically unable to speak or make himself understood even with a communication device, the assistant's services may be necessary for the length of time the individual is at work or school or both. Workplace or school supports through the HIV/AIDS waiver are not provided if the services are an employer's responsibility under the Americans with Disabilities Act or § 504 of the Rehabilitation Act.

C. The provider agency must develop an individualized plan of care that addresses the individual's needs at home, at work or school and in the community. DMAS will not pay for the assistant to assist the enrolled individual with any functions related to the individual completing his job or school functions or for supervision time during work, school, or both.

D. Special provider participation conditions. The personal care provider shall:

1. Operate from a business office.

2. Employ (or subcontract with) and directly supervise a registered nurse who will provide ongoing supervision of all personal care aides.

a. The registered nurse shall be currently licensed to practice in the Commonwealth of Virginia and have at least two years of related clinical nursing experience (which may include work in an acute care hospital, public health clinic, home health agency, rehabilitation hospital, nursing facility, or as a licensed practical nurse (LPN)).

b. The registered nurse shall have a satisfactory work record, as evidenced by references from prior job experience, including no evidence of abuse, neglect, or exploitation of incapacitated or older adults and children. Providers are responsible for complying with § 32.1-162.9:1 of the Code of Virginia regarding criminal record checks. The criminal record check documentation shall be available for review by DMAS staff who are authorized by the agency to review these files, as a part of the utilization review process.

c. The registered nurse supervisor shall make an initial home assessment on or before the start of care for all new individuals admitted to personal care, when individuals are readmitted after being discharged from services, or are transferred from another personal care provider.

d. The registered nurse supervisor shall make supervisory visits as often as needed, but no fewer visits than provided as follows, to ensure both quality and appropriateness of services.

(1) A minimum frequency of these visits is every 30 days for individuals with a cognitive impairment, as defined herein, and every 90 days for individuals who do not have a cognitive impairment.

(2) The initial home assessment visit by the registered nurse shall be conducted to create the plan of care and assess individuals' needs. The registered nurse shall return for a follow-up visit within 30 days after the initial visit to assess the individual's needs and make a final determination that there is no cognitive impairment. This determination must be documented in the individual's record by the registered nurse. Individuals who are determined to have a cognitive impairment will continue to have supervisory visits every 30 days.

(3) If there is no cognitive impairment, the registered nurse may give the individual or caregiver or both the option of having the supervisory visit every 90 days or any increment in between, not to exceed 90 days. The registered nurse must document this conversation in the individual's record and the option that was chosen.

(4) The provider has the responsibility of determining if 30-day registered nurse supervisory visits are appropriate for the individual. The provider may offer the extended registered nurse supervisory visits, or the agency may choose to continue the 30-day supervisory visits based on the needs of the individual. The decision must be documented in the individual's record.

(5) If an individual's personal care assistant is supervised by the provider's registered nurse less often than every 30 days and DMAS or the designated preauthorization contractor determines that the individual's health, safety, or welfare is in jeopardy, DMAS or the designated preauthorization contractor may require the provider's registered nurse to supervise the personal care aide every 30 days or more frequently than what has been determined by the registered nurse. This will be documented and entered in the individual's record.

e. During visits to the individual's home, the registered nurse shall observe, evaluate, and document the adequacy and appropriateness of personal care services

with regard to the individual's current functioning status, medical, and social needs. The personal care aide's record shall be reviewed and the recipient's (or family's) satisfaction with the type and amount of service discussed. The registered nurse summary shall note:

(1) Whether personal care services continue to be appropriate.

(2) Whether the plan is adequate to meet the individual's needs or if changes need to be made in the plan of care.

(3) Any special tasks performed by the aide and the aide's qualifications to perform these tasks.

(4) Individual's satisfaction with the service.

(5) Hospitalization or change in the medical condition or functioning status of the individual.

(6) Other services received by the individual and the amount; and

(7) The presence or absence of the aide in the home during the registered nurse's visit.

f. A registered nurse shall be available to the personal care aide for conference pertaining to individuals being served by the aide and shall be available to aides by telephone at all times that the aide is providing services to personal care individuals.

g. The registered nurse supervisor shall evaluate the aides' performance and the individual's needs to identify any insufficiencies in the aide's abilities to function competently and shall provide training as indicated. This shall be documented in the individual's record.

h. If there is a delay in the registered nurses' supervisory visits, because the individual was unavailable, the reason for the delay must be documented in the individual's record.

3. Employ and directly supervise personal care aides who provide direct care to personal care individuals. Each aide hired by the provider agency shall be evaluated by the provider agency to ensure compliance with qualifications required by DMAS. Each aide shall:

a. Be able to read and write.

b. Complete a minimum of 40 hours of training consistent with DMAS standards. Prior to assigning an aide to an individual, the provider agency shall ensure that the aide has satisfactorily completed a training program consistent with DMAS standards.

c. Be physically able to do the work.

d. Have a satisfactory work record, as evidenced by references from prior job experience, including no evidence of abuse, neglect or exploitation of incapacitated or older adults and children. Providers are responsible for complying with § 32.1-162.9:1 of the Code of Virginia regarding criminal record checks. The criminal record check shall be available for review by DMAS staff who are authorized by the agency to review these files; and

e. Not be (i) the parents of minor children who are receiving waiver services or (ii) spouses of individuals who are receiving waiver services.

Payment may be made for services furnished by other family members when there is objective written documentation as to why there are no other providers available to provide the care. These family members must meet the same requirements as aides who are not family members.

~~C.~~ E. Required documentation for individuals' records. The provider agency shall maintain all records of each personal care recipient. These records shall be separate from those of nonhome and community-based care services, such as companion or home health services. These records shall be reviewed periodically by the DMAS staff who are authorized by DMAS to review these files during utilization review. At a minimum these records shall contain:

1. The most recently updated Long Term Care Uniform Assessment Instrument (UAI), documentation of any inpatient hospital admissions, the Medicaid-Funded Long-Term Care Service Authorization form (DMAS-96), the Screening Team Service Plan for Medicaid-Funded Long-Term Care (DMAS-97), the Consent to Exchange Information (DMAS-20), all Provider Agency Plans of Care (DMAS—97A), all Community-Based Care Recipient Assessment Reports (DMAS-99), all Patient Information Forms (DMAS-122), and the Service Agreement Between the Consumer and the Service Facilitator.

2. The initial assessment by a registered nurse completed prior to or on the date that services are initiated.

3. Registered nurses' notes recorded and dated during any significant contacts with the personal care aide and during supervisory visits to the individual's home.

4. All correspondence to the individual, DMAS, the designated preauthorization contractor.

5. Reassessments made during the provision of services.

6. Significant contacts made with family, physicians, DMAS, the designated preauthorization contractor, formal and informal service providers and all professionals related to the individual's Medicaid services or medical care.

7. All Provider Aide/LPN Records (DMAS-90). The Provider Aide/LPN Record shall contain:

a. The specific services delivered to the individual by the aide and the individual's response to this service;

b. The aide's daily arrival and departure times;

c. The aide's weekly comments or observations about the individual, including observations of the individual's physical and emotional condition, daily activities, and responses to services rendered; and

d. The aide's and individual's, or responsible caregiver's, weekly signatures, including the date, to verify that personal care services have been rendered during that week as documented in the record. An employee of the provider cannot sign for the individual unless he is a family member or legal guardian of the individual.

Signatures, times and dates shall not be placed on the aide record prior to the last date of the week that the services are delivered.

8. All individual progress reports.

12VAC30-120-190. Agency-directed respite care services.

A. General. Agency-directed respite care services may be offered to individuals as an alternative to institutional care. Respite care may be offered to individuals in their homes or places of residence, in a Medicaid-certified nursing facility, or in a licensed respite care facility. Respite care is distinguished from other services in the continuum of long-term care because it is specifically designed to focus on the need of the unpaid primary caregiver for temporary relief. Respite care may only be offered to individuals who have an unpaid primary caregiver living in the home who requires temporary relief to avoid institutionalization of the individual. ~~The~~ Effective July 1, 2011, the authorization of respite care is limited to ~~720~~ 480 hours per ~~calendar~~ year per individual. An individual who transfers to a different provider or is discharged and readmitted into the HIV/AIDS waiver program within the same ~~calendar~~ year will not receive an additional ~~720~~ 480 hours of respite care. Reimbursement shall be made on an hourly basis not to exceed a total of ~~720~~ 480 hours per ~~calendar~~ year. If an individual is receiving both agency directed and consumer directed respite care, the total number of respite care hours cannot exceed a total of ~~720~~ 480 hours combined per ~~calendar~~ year.

B. Special provider participation conditions. To be approved for respite care contracts with DMAS, the respite care provider shall:

1. Operate from a business office.

2. Employ (or subcontract) with and directly supervise a registered nurse who will provide ongoing supervision of all respite care aides.

a. The registered nurse shall be currently licensed to practice in the Commonwealth and have at least two years of related clinical nursing experience which may include work in an acute care hospital, public health clinic, home health agency, rehabilitation hospital, nursing facility or as an LPN.

b. The registered nurse shall have a satisfactory work record, as evidenced by references from prior job experience, including no evidence of abuse, neglect, or exploitation of incapacitated or older adults and children. Providers are responsible for complying with § 32.1-162.9:1 of the Code of Virginia regarding criminal record checks. The criminal record check shall be available for review by DMAS staff who are authorized by the agency to review these files.

c. Based on continuing evaluations of the aides' performance and the individuals' needs, a registered nurse supervisor shall identify any insufficiencies in the aides' abilities to function competently and shall provide training as indicated.

d. A registered nurse supervisor shall make an initial home assessment visit on or before the start of care for any individual admitted to respite care.

e. A registered nurse supervisor shall make supervisory visits as often as needed to ensure both quality and appropriateness of services.

(1) When respite care services are received on a routine basis, the minimum acceptable frequency of these visits shall be every 30 days.

(2) When respite care services are not received on a routine basis, but are episodic in nature, a registered nurse shall not be required to conduct a supervisory visit every 30 days. Instead, a registered nurse shall conduct the initial home visit with the respite care aide on or before the start of care and make a second home visit during the second respite care visit.

(3) When respite care services are routine in nature and offered in conjunction with personal care, the supervisory visit conducted for personal care services may serve as the registered nurse supervisory visit for respite care. However, the registered nurse supervisor shall document supervision of respite care separately from the personal care documentation. For this purpose, the same individual record can be used with a separate section for respite care documentation.

f. During visits to the individual's home, the registered nurse shall observe, evaluate, and document the adequacy and appropriateness of respite care services with regard to the individual's current functioning status, medical, and social needs. The respite care aide's record shall be reviewed and the recipient's or family's satisfaction with the type and amount of service discussed. The registered nurse shall document in a summary note:

(1) Whether respite care services continue to be appropriate;

(2) Whether the plan of care is adequate to meet the individual's needs or if changes need to be made in the plan of care;

(3) The individual's satisfaction with the service;

(4) Any hospitalization or change in the medical condition or functioning status of the individual;

(5) Other services received by the individual and the amount of services received; and

(6) The presence or absence of the aide in the home during the registered nurse's visit.

g. A registered nurse shall be available to the respite care aide for conference pertaining to individuals being served by the aide and shall be available to the aides by telephone at all times that aides are providing services to respite care individuals.

h. If there is a delay in the registered nurse's supervisory visits because the individual is unavailable, the reason for the delay must be documented in the individual's record.

3. Employ and directly supervise respite care aides who provide direct care to respite care individuals. Each aide hired by the provider agency shall be evaluated by the provider agency to ensure compliance with qualifications as required by DMAS. Each aide must:

a. Be able to read and write in English to the degree necessary to perform the tasks expected.

b. Have completed a minimum 40 hours of training consistent with DMAS standards. Prior to assigning an aide to an individual, the provider agency shall ensure that the aide has satisfactorily completed a training program consistent with DMAS standards.

c. Be evaluated in his job performance by the registered nurse supervisor.

d. Be physically able to do the work.

e. Have a satisfactory work record, as evidenced by references from prior job experience, including no evidence of abuse, neglect, or exploitation of incapacitated or older adults and children. Providers are responsible for complying with § 32.1-162.9:1 of the Code of Virginia regarding criminal record checks. The criminal record check documentation shall be available for review by DMAS staff who are authorized by the agency to review these files.

f. Not be (i) the parents of minor children who are receiving waiver services or (ii) the spouses of individuals who are receiving waiver services. Payment may be made for services furnished by other family members when there is objective written documentation as to why there are no other providers available to provide the care. These family members must meet the same requirements as aides who are not family members.

4. The respite care agency may employ a licensed practical nurse (LPN) to perform skilled respite care services which shall be reimbursed by DMAS under the following circumstances:

a. The LPN shall be currently licensed to practice in the Commonwealth. The LPN must have a satisfactory work record, as evidenced by references from prior job experience, including no evidence of abuse, neglect, or exploitation of incapacitated or older adults and children. Providers shall be responsible for complying with § 32.1-162.9:1 of the Code of Virginia regarding criminal record checks. The criminal record check documentation shall be available for review by DMAS staff who are authorized by the agency to review these files.

b. The individual has a need for routine skilled care that cannot be provided by unlicensed personnel. This individual would typically require a skilled level of care if in a nursing facility (i.e., individuals on a ventilator, individuals requiring nasogastric or gastrostomy feedings, etc.).

c. No other person in the individual's support system is able to supply the skilled component of the individual's care during the caregiver's absence.

d. The individual is unable to receive skilled nursing visits from any other source which could provide the skilled care usually given by the caregiver.

e. The agency must document in the individual's record the circumstances which require the provision of services by an LPN.

f. A physician's order for the skilled respite service, on the Home Health Certification and Plan of Care (CMS-485) is obtained prior to the initiation of service and is updated every six months. This order must specifically identify the skilled tasks to be performed.

The registered nurse shall review the medications and treatments rendered by the LPN every 60 days and verify the physician's orders.

C. Required documentation for individuals' records. The provider agency shall maintain all records of each respite care individual. These records shall be separate from those of nonhome and community-based care services, such as companion or home health services. These records shall be reviewed periodically by the DMAS staff who are authorized by the agency to review these files during utilization review. At a minimum these records shall contain:

1. The most recently updated Long Term Care Uniform Assessment Instrument (UAI), documentation of any inpatient hospital admissions, the Medicaid-Funded Long-Term Care Service Authorization form (DMAS-96), the Screening Team Service Plan for Medicaid-Funded Long-Term Care (DMAS-97), all Community-Based Care Assessment Reports (DMAS-99), all Provider Agency Plans of Care (DMAS-97A and CMS-485), and all Patient Information Forms (DMAS-122)~~;~~ .

2. The initial assessment by a registered nurse completed prior to or on the date services are initiated.

3. Registered nurse's notes recorded and dated during significant contacts with the respite care aide or LPN and during supervisory visits to the individual's home.

4. All correspondence to the individual, DMAS, and the designated preauthorization contractor.

5. Reassessments made during the provision of services.

6. Significant contacts made with family, physicians, DMAS, the designated preauthorization contractor, formal and informal service providers, and all professionals related to the individual's Medicaid services or medical care.

7. All Provider Aide/LPN Records (DMAS-90). The provider aide/LPN record shall contain:

a. The specific services delivered to the individual by the respite care aide, or LPN, and the individual's response to this service.

b. The daily arrival and departure times of the aide or LPN for respite care services.

c. Comments or observations recorded weekly about the individual. Aide or LPN comments shall include but not be limited to observation of the individual's physical and emotional condition, daily activities, and the individual's response to services rendered.

d. The signatures of the aide, or LPN, and the individual once each week to verify that respite care services have been rendered.

Signatures, times, and dates shall not be placed on the aide record prior to the last date of the week that the services are delivered. If the individual is unable to sign the aide record, it must be documented in the individual's record how or who will sign in his place. An employee of the provider shall not sign for the individual unless he is a family member or legal guardian of the individual and has direct knowledge of the care received by the individual.

8. All recipient progress reports.

12VAC30-120-225. Consumer-directed model of service delivery.

A. Criteria.

1. The MR Waiver has three services, companion, personal assistance, and respite, that may be provided through a consumer-directed model. Effective July 1, 2011, respite services shall be limited to 480 hours per year.

2. Individuals who choose the consumer-directed model must have the capability to hire, train, and fire their own personal assistant or companion and supervise the assistant's or companion's performance. If an individual is unable to direct his own care or is under 18 years of age, a family/caregiver may serve as the employer on behalf of the individual.

3. The individual, or if the individual is unable, then family/caregiver, shall be the employer in this service, and therefore shall be responsible for hiring, training, supervising, and firing assistants and companions. Specific employer duties include checking of references of personal assistants/companions, determining that personal assistants/companions meet basic qualifications, training assistants/companions, supervising the assistant's/companion's performance, and submitting timesheets to the fiscal agent on a consistent and timely basis. The individual and the individual's family/caregiver, as appropriate, must have a back-up plan in case the assistant/companion does not show up for work as expected or terminates employment without prior notice.

4. Individuals choosing consumer-directed models of service delivery must receive support from a CD services facilitator. This is not a separate waiver service, but is required in conjunction with consumer-directed personal assistance, respite, or companion services. The CD services facilitator will be responsible for assessing the individual's particular needs for a requested CD service, assisting in the development of the ISP, providing training to the individual and the individual's family/caregiver, as appropriate, on his responsibilities as an employer, and providing ongoing support of the consumer-directed models of services. The CD services facilitator cannot be the individual, the individual's case manager, direct service provider, spouse, or parent of the individual who is a minor child, or a family/caregiver employing the assistant/companion. If an individual enrolled in consumer-directed services has a lapse in services facilitator for more than 90 consecutive days, the case manager must notify DMHMRSAS and the consumer-directed services will be discontinued.

5. DMAS shall provide for fiscal agent services for consumer-directed personal assistance services, consumer-directed companion services, and consumer-directed respite services. The fiscal agent will be reimbursed by

DMAS to perform certain tasks as an agent for the individual/employer who is receiving consumer-directed services. The fiscal agent will handle the responsibilities of employment taxes for the individual. The fiscal agent will seek and obtain all necessary authorizations and approvals of the Internal Revenue Services in order to fulfill all of these duties.

B. Provider qualifications. In addition to meeting the general conditions and requirements for home and community-based services participating providers as specified in 12VAC30-120-217 and 12VAC30-120-219, the CD services facilitator must meet the following qualifications:

1. To be enrolled as a Medicaid CD services facilitator and maintain provider status, the CD services facilitator shall have sufficient resources to perform the required activities. In addition, the CD services facilitator must have the ability to maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the services provided.

2. It is preferred that the CD services facilitator possess a minimum of an undergraduate degree in a human services field or be a registered nurse currently licensed to practice in the Commonwealth. In addition, it is preferable that the CD services facilitator have two years of satisfactory experience in a human service field working with persons with mental retardation. The facilitator must possess a combination of work experience and relevant education that indicates possession of the following knowledge, skills, and abilities. Such knowledge, skills, and abilities must be documented on the provider's application form, found in supporting documentation, or be observed during a job interview. Observations during the interview must be documented. The knowledge, skills, and abilities include:

a. Knowledge of:

(1) Types of functional limitations and health problems that may occur in persons with mental retardation, or persons with other disabilities, as well as strategies to reduce limitations and health problems;

(2) Physical assistance that may be required by people with mental retardation, such as transferring, bathing techniques, bowel and bladder care, and the approximate time those activities normally take;

(3) Equipment and environmental modifications that may be required by people with mental retardation that reduce the need for human help and improve safety;

(4) Various long-term care program requirements, including nursing home and ICF/MR placement criteria, Medicaid waiver services, and other federal, state, and local resources that provide personal assistance, respite, and companion services;

(5) MR waiver requirements, as well as the administrative duties for which the services facilitator will be responsible;

(6) Conducting assessments (including environmental, psychosocial, health, and functional factors) and their uses in service planning;

(7) Interviewing techniques;

(8) The individual's right to make decisions about, direct the provisions of, and control his consumer-directed personal assistance, companion and respite services, including hiring, training, managing, approving time sheets, and firing an assistant/companion;

(9) The principles of human behavior and interpersonal relationships; and

(10) General principles of record documentation.

b. Skills in:

(1) Negotiating with individuals and the individual's family/caregivers, as appropriate, and service providers;

(2) Assessing, supporting, observing, recording, and reporting behaviors;

(3) Identifying, developing, or providing services to individuals with mental retardation; and

(4) Identifying services within the established services system to meet the individual's needs.

c. Abilities to:

(1) Report findings of the assessment or onsite visit, either in writing or an alternative format for individuals who have visual impairments;

(2) Demonstrate a positive regard for individuals and their families;

(3) Be persistent and remain objective;

(4) Work independently, performing position duties under general supervision;

(5) Communicate effectively, orally and in writing; and

(6) Develop a rapport and communicate with persons of diverse cultural backgrounds.

3. If the CD services facilitator is not a RN, the CD services facilitator must inform the primary health care provider that services are being provided and request skilled nursing or other consultation as needed.

4. Initiation of services and service monitoring.

a. For consumer-directed services, the CD services facilitator must make an initial comprehensive home visit to collaborate with the individual and the individual's family/caregiver, as appropriate, to identify the needs,

assist in the development of the ISP with the individual and the individual's family/caregiver, as appropriate, and provide employee management training. The initial comprehensive home visit is done only once upon the individual's entry into the consumer-directed model of service regardless of the number or type of consumer-directed services that an individual chooses to receive. If an individual changes CD services facilitators, the new CD services facilitator must complete a reassessment visit in lieu of a comprehensive visit.

b. After the initial visit, the CD services facilitator will continue to monitor the companion, or personal assistant ISP quarterly and on an as-needed basis. The CD services facilitator will review the utilization of consumer-directed respite services, either every six months or upon the use of ~~300~~ 240 respite services hours, whichever comes first.

c. A face-to-face meeting with the individual must be conducted at least every six months to reassess the individual's needs and to ensure appropriateness of any CD services received by the individual.

5. During visits with the individual, the CD services facilitator must observe, evaluate, and consult with the individual and the individual's family/caregiver, as appropriate, and document the adequacy and appropriateness of consumer-directed services with regard to the individual's current functioning and cognitive status, medical needs, and social needs.

6. The CD services facilitator must be available to the individual by telephone.

7. The CD services facilitator must submit a criminal record check pertaining to the assistant/companion on behalf of the individual and report findings of the criminal record check to the individual and the individual's family/caregiver, as appropriate, and the program's fiscal agent. If the individual is a minor, the assistant/companion must also be screened through the DSS Child Protective Services Central Registry. Assistants/companions will not be reimbursed for services provided to the individual effective the date that the criminal record check confirms an assistant/companion has been found to have been convicted of a crime as described in § 37.2-416 of the Code of Virginia or if the assistant/companion has a confirmed record on the DSS Child Protective Services Central Registry. The criminal record check and DSS Child Protective Services Central Registry finding must be requested by the CD services facilitator within 15 calendar days of employment. The services facilitator must maintain evidence that a criminal record check was obtained and must make such evidence available for DMAS review.

8. The CD services facilitator shall review timesheets during the face-to-face visits or more often as needed to ensure that the number of ISP-approved hours is not exceeded. If discrepancies are identified, the CD services facilitator must discuss these with the individual to resolve discrepancies and must notify the fiscal agent.

9. The CD services facilitator must maintain a list of persons who are available to provide consumer-directed personal assistance, consumer-directed companion, or consumer-directed respite services.

10. The CD services facilitator must maintain records of each individual as described in 12VAC30-120-217, 12VAC30-120-223, and 12VAC30-120-233.

11. Upon the individual's request, the CD services facilitator shall provide the individual and the individual's family/caregiver, as appropriate, with a list of persons who can provide temporary assistance until the assistant/companion returns or the individual is able to select and hire a new personal assistant/companion. If an individual is consistently unable to hire and retain the employment of an assistant/companion to provide consumer-directed personal assistance, companion, or respite services, the CD services facilitator will make arrangements with the case manager to have the services transferred to an agency-directed services provider or to discuss with the individual and the individual's family/caregiver, as appropriate, other service options.

12VAC30-120-233. Personal assistance and respite services.

A. Service description. Services may be provided either through an agency-directed or consumer-directed model.

1. Personal assistance services are provided to individuals in the areas of activities of daily living, instrumental activities of daily living, access to the community, monitoring of self-administered medications or other medical needs, monitoring of health status and physical condition, and work-related personal assistance. They may be provided in home and community settings to enable an individual to maintain the health status and functional skills necessary to live in the community or participate in community activities. When specified, such supportive services may include assistance with instrumental activities of daily living (IADLs). Personal assistance does not include either practical or professional nursing services or those practices regulated in Chapters 30 (§ 54.1-3000 et seq.) and 34 (§ 54.1-3400 et seq.) of Title 54.1 of the Code of Virginia, as appropriate. This service does not include skilled nursing services with the exception of skilled nursing tasks that may be delegated pursuant to 18VAC90-20-420 through 18VAC90-20-460.

2. Respite services are supports for that which is normally provided by the family or other unpaid primary caregiver of an individual. These services are furnished on a short-term basis because of the absence or need for relief of

those unpaid caregivers normally providing the care for the individuals.

B. Criteria.

1. In order to qualify for personal assistance services, the individual must demonstrate a need for assistance with activities of daily living, community access, self-administration of medications or other medical needs, or monitoring of health status or physical condition.

2. Respite services may only be offered to individuals who have an unpaid primary caregiver who requires temporary relief to avoid institutionalization of the individual.

C. Service units and service limitations.

1. The unit of service is one hour.

2. Each individual must have a back-up plan in case the personal assistant does not show up for work as expected or terminates employment without prior notice.

3. Personal assistance is not available to individuals: (i) who receive congregate residential services or live in assisted living facilities; (ii) who would benefit from personal assistance training and skill development; or (iii) who receive comparable services provided through another program or service.

4. Respite services shall not be provided to relieve group home or assisted living facility staff where residential care is provided in shifts. Respite services shall not be provided by adult foster care providers for an individual residing in that home. Training of the individual is not provided with respite services.

5. ~~Respite~~ Effective July 1, 2011, respite services shall be limited to a maximum of ~~720~~ 480 hours per ~~calendar~~ year. Individuals who are receiving services through both the agency-directed and consumer-directed model cannot exceed ~~720~~ 480 hours per ~~calendar~~ year combined.

6. ~~The~~ Within the limits established herein, the hours authorized are based on individual need. No more than two unrelated individuals who live in the same home are permitted to share the authorized work hours of the assistant.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-217 and 12VAC30-120-219, personal assistance and respite providers must meet additional provider requirements:

1. Services shall be provided by:

a. For the agency-directed model, an enrolled DMAS personal care/respite care provider or by a DMHMRSAS-licensed residential services provider. In addition, respite services may be provided by a DMHMRSAS-licensed respite services provider or a DSS-approved foster care home for children or adult foster home provider. All personal assistants must pass an objective standardized test of skills, knowledge, and abilities approved by DMHMRSAS and administered according to DMHMRSAS' defined procedures.

b. For consumer-directed model, a services facilitator meeting the requirements found in 12VAC30-120-225.

2. For DMHMRSAS-licensed residential or respite services providers, a residential or respite supervisor will provide ongoing supervision of all assistants.

3. For DMAS-enrolled personal care/respite care providers, the provider must employ or subcontract with and directly supervise a RN or a LPN who will provide ongoing supervision of all assistants. The supervising RN or LPN must be currently licensed to practice nursing in the Commonwealth and have at least two years of related clinical nursing experience that may include work in an acute care hospital, public health clinic, home health agency, ICF/MR or nursing facility.

4. The supervisor or services facilitator must make a home visit to conduct an initial assessment prior to the start of services for all individuals requesting personal assistance or respite services. The supervisor or services facilitator must also perform any subsequent reassessments or changes to the supporting documentation.

5. The supervisor or services facilitator must make supervisory home visits as often as needed to ensure both quality and appropriateness of services. The minimum frequency of these visits is every 30 to 90 days under the agency-directed model and semi-annually (every six months) under the consumer-directed model depending on the individual's needs.

a. When respite services are not received on a routine basis, but are episodic in nature, the supervisor or services facilitator is not required to conduct a supervisory visit every 30 to 90 days. Instead, the supervisor or services facilitator must conduct the initial home visit with the respite assistant immediately preceding the start of services and make a second home visit within the respite period.

b. When respite services are routine in nature and offered in conjunction with personal assistance, the supervisory visit conducted for personal assistance may serve as the supervisory visit for respite services. However, the supervisor or services facilitator must document supervision of respite services separately. For this purpose, the same individual record can be used with a separate section for respite services documentation.

6. Based on continuing evaluations of the assistant's performance and individual's needs, the supervisor or services facilitator shall identify any gaps in the assistant's

ability to function competently and shall provide training as indicated.

7. Qualification of assistants.

a. The assistant must:

(1) Be 18 years of age or older and possess a valid social security number;

(2) Be able to read and write English to the degree necessary to perform the tasks expected and possess basic math skills; and

(3) Have the required skills to perform services as specified in the individual's ISP.

b. Additional requirements for DMAS-enrolled personal care/respite care providers.

(1) Assistants must complete a training curriculum consistent with DMAS requirements. Prior to assigning an assistant to an individual, the provider must obtain documentation that the assistant has satisfactorily completed a training program consistent with DMAS requirements. DMAS requirements may be met in one of three ways:

(a) Registration as a certified nurse aide;

(b) Graduation from an approved educational curriculum that offers certificates qualifying the student as a nursing assistant, geriatric assistance, or home health aide;

(c) Completion of provider-offered training, which is consistent with the basic course outline approved by DMAS; and

(2) Assistants must have a satisfactory work record, as evidenced by two references from prior job experiences, including no evidence of possible abuse, neglect, or exploitation of aged or incapacitated adults or children.

c. Additional requirements for the consumer-directed option. The assistant must:

(1) Submit to a criminal records check and, if the individual is a minor, consent to a search of the DSS Child Protective Services Central Registry. The assistant will not be compensated for services provided to the individual if either of these records checks verifies the assistant has been convicted of crimes described in § 37.2-416 of the Code of Virginia or if the assistant has a founded complaint confirmed by the DSS Child Protective Services Central Registry;

(2) Be willing to attend training at the individual and the individual's family/caregiver, as appropriate, request;

(3) Understand and agree to comply with the DMAS MR Waiver requirements; and

(4) Receive an annual tuberculosis (TB) screening.

8. Assistants may not be the parents of individuals who are minors, or the individuals' spouses. Payment may not be made for services furnished by other family members living under the same roof as the individual receiving services unless there is objective written documentation as to why there are no other providers available to provide the service. Family members who are approved to be reimbursed for providing this service must meet the assistant qualifications.

9. Provider inability to render services and substitution of assistants (agency-directed model).

a. When an assistant is absent, the provider is responsible for ensuring that services continue to be provided to individuals. The provider may either provide another assistant, obtain a substitute assistant from another provider, if the lapse in coverage is to be less than two weeks in duration, or transfer the individual's services to another provider. The provider that has the authorization to provide services to the individual must contact the case manager to determine if additional preauthorization is necessary.

b. If no other provider is available who can supply a substitute assistant, the provider shall notify the individual and the individual's family/caregiver, as appropriate, and case manager so that the case manager may find another available provider of the individual's choice.

c. During temporary, short-term lapses in coverage not to exceed two weeks in duration, the following procedures must apply:

(1) The preauthorized provider must provide the supervision for the substitute assistant;

(2) The provider of the substitute assistant must send a copy of the assistant's daily documentation signed by the individual and the individual's family/caregiver, as appropriate, on his behalf and the assistant to the provider having the authorization; and

(3) The preauthorized provider must bill DMAS for services rendered by the substitute assistant.

d. If a provider secures a substitute assistant, the provider agency is responsible for ensuring that all DMAS requirements continue to be met including documentation of services rendered by the substitute assistant and documentation that the substitute assistant's qualifications meet DMAS' requirements. The two providers involved are responsible for negotiating the financial arrangements of paying the substitute assistant.

10. Required documentation in the individual's record. The provider must maintain records regarding each individual receiving services. At a minimum these records must contain:

a. An initial assessment completed by the supervisor or services facilitator prior to or on the date services are initiated;

b. An ISP, that contains, at a minimum, the following elements:

(1) The individual's strengths, desired outcomes, required or desired supports;

(2) The individual's goals and objectives to meet the above identified outcomes;

(3) Services to be rendered and the frequency of services to accomplish the above goals and objectives; and

(4) For the agency-directed model, the provider staff responsible for the overall coordination and integration of the services specified in the ISP.

c. The ISP goals, objectives, and activities must be reviewed by the supervisor or services facilitator quarterly for personal assistance only, annually, and more often as needed modified as appropriate and results of these reviews submitted to the case manager. For the annual review and in cases where the ISP is modified, the ISP must be reviewed with the individual.

d. Dated notes of any contacts with the assistant, individual and the individual's family/caregiver, as appropriate, during supervisory or services facilitator visits to the individual's home. The written summary of the supervision or services facilitation visits must include:

(1) Whether services continue to be appropriate and whether the ISP is adequate to meet the need or if changes are indicated in the ISP;

(2) Any suspected abuse, neglect, or exploitation and to whom it was reported;

(3) Any special tasks performed by the assistant and the assistant's qualifications to perform these tasks;

(4) The individual's satisfaction with the service;

(5) Any hospitalization or change in medical condition or functioning status;

(6) Other services received and their amount; and

(7) The presence or absence of the assistant in the home during the supervisor's visit.

e. All correspondence to the individual and the individual's family/caregiver, as appropriate, case manager, DMAS, and DMHMRSAS;

f. Reassessments and any changes to supporting documentation made during the provision of services;

g. Contacts made with the individual, family/caregivers, physicians, formal and informal service providers, and all professionals concerning the individual;

h. Copy of the most recently completed DMAS-122 form. The provider or services facilitator must clearly document efforts to obtain the completed DMAS-122 form from the case manager.

i. For the agency-directed model, the assistant record must contain:

(1) The specific services delivered to the individual by the assistant, dated the day of service delivery, and the individual's responses;

(2) The assistant's arrival and departure times;

(3) The assistant's weekly comments or observations about the individual to include observations of the individual's physical and emotional condition, daily activities, and responses to services rendered; and

(4) The assistant's and individual's and the individual's family/caregiver's, as appropriate, weekly signatures recorded on the last day of service delivery for any given week to verify that services during that week have been rendered.

j. For individuals receiving personal assistance and respite services in a congregate residential setting, because services that are training in nature are currently or no longer appropriate or desired, the record must contain:

(1) The specific services delivered to the individual, dated the day services were provided, the number of hours as outlined in the ISP, the individual's responses, and observations of the individual's physical and emotional condition; and

(2) At a minimum, monthly verification by the residential supervisor of the services and hours and quarterly verification as outlined in 12VAC30-120-241.

k. For the consumer-directed model, the assistant record must contain:

(1) Documentation of all training provided to the assistants on behalf of the individual and the individual's family/caregiver, as appropriate;

(2) Documentation of all employee management training provided to the individual and the individual's family/caregiver, as appropriate, including the individual and the individual's family/caregiver, as appropriate, receipt of training on their responsibility for the accuracy of the assistant's timesheets;

(3) All documents signed by the individual and the individual's family/caregiver, as appropriate, that acknowledge the responsibilities as the employer.

12VAC30-120-766. Personal care and respite care services.

A. Service description. Services may be provided either through an agency-directed or consumer-directed model.

1. Personal care services means services offered to individuals in their homes and communities to enable an individual to maintain the health status and functional skills necessary to live in the community or participate in community activities. Personal care services substitute for the absence, loss, diminution, or impairment of a physical, behavioral, or cognitive function. This service shall provide care to individuals with activities of daily living (eating, drinking, personal hygiene, toileting, transferring and bowel/bladder control), instrumental activities of daily living (IADL), access to the community, monitoring of self-medication or other medical needs, and the monitoring of health status or physical condition. In order to receive personal care services, the individual must require assistance with their ADLs. When specified in the plan of care, personal care services may include assistance with IADL. Assistance with IADL must be essential to the health and welfare of the individual, rather than the individual's family/caregiver. An additional component to personal care is work or school-related personal care. This allows the personal care provider to provide assistance and supports for individuals in the workplace and for those individuals attending postsecondary educational institutions. Workplace or school supports through the IFDDS Waiver are not provided if they are services that should be provided by the Department of Rehabilitative Services, under IDEA, or if they are an employer's responsibility under the Americans with Disabilities Act, the Virginians with Disabilities Act, or § 504 of the Rehabilitation Act. Work-related personal care services cannot duplicate services provided under supported employment.

2. Respite care means services provided for unpaid caregivers of eligible individuals who are unable to care for themselves that are provided on an episodic or routine basis because of the absence of or need for relief of those unpaid persons who routinely provide the care.

B. Criteria.

1. In order to qualify for personal care services, the individual must demonstrate a need in activities of daily living, reminders to take medication, or other medical needs, or monitoring health status or physical condition.

2. In order to qualify for respite care, individuals must have an unpaid primary caregiver who requires temporary relief to avoid institutionalization of the individual.

3. Individuals choosing the consumer-directed option must receive support from a CD services facilitator and meet requirements for consumer direction as described in 12VAC30-120-770.

C. Service units and service limitations.

1. The unit of service is one hour.

2. ~~Respite~~ Effective July 1, 2011, respite care services are limited to a maximum of ~~720~~ 480 hours per year. Individuals who are receiving services through both the agency-directed and consumer-directed models cannot exceed ~~720~~ 480 hours per ~~calendar~~ year combined.

3. Individuals may have personal care, respite care, and in-home residential support services in their plan of care but cannot receive in-home residential supports and personal care or respite care services at the same time.

4. Each individual receiving personal care services must have a back-up plan in case the personal care aide or consumer-directed (CD) employee does not show up for work as expected or terminates employment without prior notice.

5. Individuals must need assistance with ADLs in order to receive IADL care through personal care services.

6. Individuals shall be permitted to share personal care service hours with one other individual (receiving waiver services) who lives in the same home.

7. This service does not include skilled nursing services with the exception of skilled nursing tasks that may be delegated in accordance with 18VAC90-20-420 through 18VAC90-20-460.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12VAC30-120-730 and 12VAC30-120-740, personal and respite care providers must meet the following provider requirements:

1. Services shall be provided by:

a. For the agency-directed model, a DMAS enrolled personal care/respite care provider or by a DMHMRSAS-licensed residential supportive in-home provider. All personal care aides must pass an objective standardized test of knowledge, skills, and abilities approved by DMHMRSAS and administered according to DMHMRSAS' defined procedures.

Providers must demonstrate a prior successful health care delivery business and operate from a business office.

b. For the consumer-directed model, a service facilitation provider meeting the requirements found in 12VAC30-120-770.

2. For DMHMRSAS-licensed providers, a residential supervisor shall provide ongoing supervision for all personal care aides. For DMAS-enrolled personal

care/respite care providers, the provider must employ or subcontract with and directly supervise an RN who will provide ongoing supervision of all aides. The supervising RN must be currently licensed to practice in the Commonwealth and have at least two years of related clinical nursing experience that may include work in an acute care hospital, public health clinic, home health agency, ICF/MR or nursing facility.

3. The RN supervisor or case manager/services facilitator must make a home visit to conduct an initial assessment prior to the start of care for all individuals requesting services. The RN supervisor or case manager/service facilitator must also perform any subsequent reassessments or changes to the supporting documentation. Under the consumer-directed model, the initial comprehensive visit is done only once upon the individual's entry into the service. If an individual served under the waiver changes CD services facilitation agencies, the new CD services facilitation provider must bill for a reassessment in lieu of a comprehensive visit.

4. The RN supervisor or case manager/services facilitator must make supervisory visits as often as needed to ensure both quality and appropriateness of services.

a. For personal care the minimum frequency of these visits is every 30 to 90 calendar days depending on individual needs. For respite care offered on a routine basis, the minimum frequency of these visits is every 30 to 90 calendar days under the agency-directed model and every six months or upon the use of ~~300~~ 240 respite care hours (whichever comes first) under the consumer-directed model.

b. Under the agency-directed model, when respite care services are not received on a routine basis, but are episodic in nature, the RN is not required to conduct a supervisory visit every 30 to 90 calendar days. Instead, the RN supervisor must conduct the initial home visit with the respite care aide immediately preceding the start of care and make a second home visit within the respite care period.

c. When respite care services are routine in nature and offered in conjunction with personal care, the 30- to 90-day supervisory visit conducted for personal care may serve as the RN supervisor or case manager/service facilitator visit for respite care. However, the RN supervisor or case manager/services facilitator must document supervision of respite care separately. For this purpose, the same record can be used with a separate section for respite care documentation.

5. Under the agency-directed model, the supervisor shall identify any gaps in the aide's ability to provide services as identified in the individual's plan of care and provide training as indicated based on continuing evaluations of the aide's performance and the individual's needs.

6. The supervising RN or case manager/services facilitator must maintain current documentation. This may be done as a summary and must note:

a. Whether personal and respite care services continue to be appropriate;

b. Whether the supporting documentation is adequate to meet the individual's needs or if changes are indicated in the supporting documentation;

c. Any special tasks performed by the aide/CD employee and the aide's/CD employee's qualifications to perform these tasks;

d. Individual's satisfaction with the service;

e. Any hospitalization or change in the individual's medical condition or functioning status;

f. Other services received and their amount; and

g. The presence or absence of the aide in the home during the RN's visit.

7. Qualification of aides/CD employees. Each aide/CD employee must:

a. Be 18 years of age or older and possess a valid social security number;

b. For the agency-directed model, be able to read and write English to the degree necessary to perform the tasks required. For the consumer-directed model, possess basic math, reading and writing skills;

c. Have the required skills to perform services as specified in the individual's plan of care;

d. Not be the parents of individuals who are minors, or the individual's spouse. Payment will not be made for services furnished by other family members living under the same roof as the individual receiving services unless there is objective written documentation as to why there are no other providers available to provide the care. Family members who are approved to be reimbursed for providing this service must meet the qualifications. In addition, under the consumer-directed model, family/caregivers acting as the employer on behalf of the individual may not also be the CD employee;

e. Additional aide requirements under the agency-directed model:

(1) Complete an appropriate aide training curriculum consistent with DMAS standards. Prior to assigning an aide to an individual, the provider must ensure that the aide has satisfactorily completed a training program consistent with DMAS standards. DMAS requirements may be met in any of the following ways:

(a) Registration as a certified nurse aide (DMAS-enrolled personal care/respite care providers);

(b) Graduation from an approved educational curriculum that offers certificates qualifying the student as a nursing assistant, geriatric assistant or home health aide (DMAS-enrolled personal care/respite care providers);

(c) Completion of provider-offered training that is consistent with the basic course outline approved by DMAS (DMAS-enrolled personal care/respite care providers);

(d) Completion and passing of the DMHMRSAS standardized test (DMHMRSAS licensed providers);

(2) Have a satisfactory work record as evidenced by two references from prior job experiences, including no evidence of possible abuse, neglect, or exploitation of aged or incapacitated adults or children; and

(3) Be evaluated in his job performance by the supervisor.

f. Additional CD employee requirements under the consumer-directed model:

(1) Submit to a criminal records check and, if the individual is a minor, the child protective services registry. The employee will not be compensated for services provided to the individual if the records check verifies the employee has been convicted of crimes described in § 37.2-314 of the Code of Virginia or if the employee has a complaint confirmed by the DSS child protective services registry;

(2) Be willing to attend training at the request of the individual or his family/caregiver, as appropriate;

(3) Understand and agree to comply with the DMAS consumer-directed services requirements; and

(4) Receive an annual TB screening.

8. Provider inability to render services and substitution of aides (agency-directed model). When an aide is absent, the provider may either obtain another aide, obtain a substitute aide from another provider if the lapse in coverage is to be less than two weeks in duration, or transfer the individual's services to another provider.

9. Retention, hiring, and substitution of employees (consumer-directed model). Upon the individual's request, the CD services facilitator shall provide the individual or his family/caregiver, as appropriate, with a list of consumer-directed employees on the consumer-directed employee registry that may provide temporary assistance until the employee returns or the individual or his family/caregiver, as appropriate, is able to select and hire a new employee. If an individual or his family/caregiver, as appropriate, is consistently unable to hire and retain an employee to provide consumer-directed services, the services facilitator must contact the case manager and DMAS to transfer the individual, at the choice of the individual or his family/caregiver, as appropriate, to a provider that provides Medicaid-funded agency-directed personal care or respite care services. The CD services facilitator will make arrangements with the case manager to have the individual transferred.

10. Required documentation in individuals' records. The provider must maintain all records of each individual receiving services. Under the agency-directed model, these records must be separated from those of other nonwaiver services, such as home health services. At a minimum these records must contain:

a. The most recently updated plan of care and supporting documentation, all provider documentation, and all DMAS-122 forms;

b. Initial assessment by the RN supervisory nurse or case manager/services facilitator completed prior to or on the date services are initiated, subsequent reassessments, and changes to the supporting documentation by the RN supervisory nurse or case manager/services facilitator;

c. Nurses' or case manager/services facilitator summarizing notes recorded and dated during any contacts with the aide or CD employee and during supervisory visits to the individual's home;

d. All correspondence to the individual and to DMAS;

e. Contacts made with family, physicians, DMAS, formal and informal service providers, and all professionals concerning the individual;

f. Under the agency-directed model, all aide records. The aide record must contain:

(1) The specific services delivered to the individual by the aide and the individual's responses;

(2) The aide's arrival and departure times;

(3) The aide's weekly comments or observations about the individual to include observations of the individual's physical and emotional condition, daily activities, and responses to services rendered; and

(4) The aide's and individual's weekly signatures to verify that services during that week have been rendered.

(5) Signatures, times, and dates; these signatures, times, and dates shall not be placed on the aide record prior to the last date of the week that the services are delivered.

(6) Copies of all aide records; these records shall be subject to review by state and federal Medicaid representatives.

g. Additional documentation requirements under the consumer-directed model:

(1) All management training provided to the individuals or their family caregivers, as appropriate, including responsibility for the accuracy of the timesheets.

(2) All documents signed by the individual or his family/caregivers, as appropriate, that acknowledge the responsibilities of the services.

12VAC30-120-950. Agency-directed personal care services.

A. This section contains requirements governing the provision of agency-directed personal care services.

B. Service description. Personal care services are comprised of hands-on care of either a supportive or health-based nature and may include, but are not limited to, assistance with activities of daily living, access to the community, monitoring of self-administered medications or other medical needs, and the monitoring of health status and physical condition. Where the individual requires assistance with activities of daily living, and where specified in the plan of care, such supportive services may include assistance with instrumental activities of daily living. This service does not include skilled nursing services with the exception of skilled nursing tasks (e.g., catheterization) that may be delegated pursuant to 18VAC90-20-420 through 18VAC90-20-460. It may be provided in a home and community setting to enable an individual to maintain the health status and functional skills necessary to live in the community or participate in community activities. Personal care may be offered either as the sole home and community-based care service or in conjunction with adult day health care, respite care (agency- or consumer-directed), or PERS.

1. Effective July 1, 2011, agency-directed personal care services shall be limited to 56 hours of services per week for 52 weeks per year.

2. Individual exceptions may be granted based on criteria established by DMAS.

C. Criteria. In order to qualify for these services, the individual must demonstrate a need for care with activities of daily living.

1. DMAS will also pay, consistent with the approved plan of care, for personal care that the personal care aide provides to the enrolled individual to assist him at work or postsecondary school. DMAS will not duplicate services that are required as a reasonable accommodation as a part of the Americans with Disabilities Act (ADA) (42 USC §§ 12131 through 12165) or the Rehabilitation Act of 1973.

2. DMAS or the designated preauthorization contractor will review the individual's needs and the complexity of the disability, as applicable, when determining the services that will be provided to him in the workplace or postsecondary school or both.

3. DMAS will not pay for the personal care aide to assist the enrolled individual with any functions related to the individual completing his job or postsecondary school functions or for supervision time during work or school or both.

4. There shall be a limit of eight hours per 24-hour day for supervision services.

5. The provider must develop an individualized plan of care that addresses the individual's needs at home and work and in the community.

D. Special provider participation conditions. The personal care provider shall:

1. Operate from a business office.

2. Employ persons who have a satisfactory work record, as evidenced by references from prior job experience, including no evidence of abuse, neglect, or exploitation of incapacitated or older adults and children. Providers are responsible for complying with § 32.1-162.9:1 of the Code of Virginia regarding criminal record checks. The criminal record check shall be available for review by DMAS staff who are authorized by DMAS to review these files.

3. Hire employees (or contract with) and directly supervise a registered nurse who will provide ongoing supervision of all personal care aides.

a. The registered nurse shall be currently licensed to practice in the Commonwealth as an RN and have at least two years of related clinical nursing experience, which may include work in an acute care hospital, public health clinic, home health agency, rehabilitation hospital, nursing facility, or as a licensed practical nurse (LPN).

b. The registered nurse supervisor shall make an initial home assessment visit on or before the start of care for all individuals admitted to personal care, when an individual is readmitted after being discharged from services, or if he is transferred from another provider, ADHC, or from a consumer-directed services program.

c. The registered nurse supervisor shall make supervisory visits as often as needed, but no fewer visits than provided as follows, to ensure both quality and appropriateness of services:

(1) A minimum frequency of these visits is every 30 days for individuals with a cognitive impairment and every 90 days for individuals who do not have a cognitive impairment, as defined herein. The provider agency shall have the responsibility of determining if 30-day registered nurse supervisory visits are appropriate for the individual.

(2) The initial home assessment visit by the registered nurse shall be conducted to create the plan of care and assess the individual's needs. The registered nurse shall return for a follow-up visit within 30 days after the initial visit to assess the individual's needs and make a final determination that there is no cognitive impairment. This determination must be documented in the individual's record by the registered nurse. Individuals who are determined to have a cognitive impairment will continue to have supervisory visits every 30 days.

(3) If there is no cognitive impairment, the registered nurse may give the individual or family/caregiver the option of having the supervisory visit every 90 days or any increment in between, not to exceed 90 days, or the provider may choose to continue the 30-day supervisory visits based on the needs of the individual. The registered nurse supervisor must document in the individual's record this conversation and the option that was chosen. The individual or the family/caregiver must sign and date this document.

(4) If an individual's personal care aide is supervised by the provider's registered nurse supervisor less frequently than every 30 days and DMAS, or the designated preauthorization contractor, determines that the individual's health, safety, or welfare is in jeopardy, DMAS, or the designated preauthorization contractor, may require the provider's registered nurse supervisor to supervise the personal care aide every 30 days or more frequently than has been determined by the registered nurse supervisor. This will be documented by the provider and entered in the individual's record.

d. During visits to the individual's home, a registered nurse supervisor shall observe, evaluate, and document the adequacy and appropriateness of personal care services with regard to the individual's current functioning status, and medical and social needs. The personal care aide's record shall be reviewed and the individual's or family's/caregiver's satisfaction with the type and amount of services discussed. The registered nurse supervisor's summary shall note:

(1) Whether personal care services continue to be appropriate;

(2) Whether the plan of care is adequate to meet the individual's needs or if changes are indicated in the plan;

(3) Any special tasks performed by the personal care aide and the personal care aide's qualifications to perform these tasks;

(4) The individual's satisfaction with the services;

(5) Whether the individual has been hospitalized or there has been a change in the medical condition or functional status of the individual;

(6) Other services received by the individual and the amount; and

(7) The presence or absence of the personal care aide in the home during the registered nurse supervisor's visit.

e. A registered nurse supervisor shall be available to the personal care aide for conferences pertaining to individuals being served by the aide and shall be available to the aide by telephone at all times that the aide is providing services to individuals.

f. The registered nurse supervisor shall evaluate the personal care aide's performance and the individual's needs to identify any insufficiencies in the personal care aide's abilities to function competently and shall provide training as indicated. This shall be documented in the individual's record.

g. If there is a delay in the registered nurses' supervisory visits because the individual was unavailable, the reason for the delay must be documented in the individual's record.

4. Employ and directly supervise personal care aides who provide direct care to individuals. Each aide hired for personal care shall be evaluated by the provider agency to ensure compliance with qualifications required by DMAS. Each personal care aide shall:

a. Be at least 18 years of age or older;

b. Be able to read and write in English to the degree necessary to perform the expected tasks;

c. Complete a minimum of 40 hours of training consistent with DMAS standards. Prior to assigning an aide to an individual, the provider agency shall ensure that the personal care aide has satisfactorily completed a DMAS-approved training program consistent with DMAS standards;

d. Be physically able to do the work; and

e. Not be (i) the parents of minor children who are receiving waiver services or (ii) spouses of individuals who are receiving waiver services.

Payment may be made for services furnished by other family members when there is objective written documentation as to why there are no other providers or aides available to provide the care. These family members must meet the same requirements as personal care aides who are not family members.

E. Required documentation for individuals' records. The provider shall maintain all records for each individual receiving personal care services. These records shall be separate from those of nonhome and community-based care services, such as companion or home health services. These

records shall be reviewed periodically by DMAS. At a minimum, the record shall contain:

1. The most recently updated Long-Term Care Uniform Assessment Instrument, the Medicaid Funded Long-Term Care Service Authorization Form (DMAS-96), the Screening Team Plan of Care for Medicaid-Funded Long-Term Care (DMAS-97), all Provider Agency Plans of Care (DMAS-97A), all Patient Information Forms (DMAS-122), and all DMAS-101A and 101B forms (if applicable);

2. The initial assessment by a registered nurse or a RN supervisor completed prior to or on the date that services are initiated;

3. Registered nurse supervisor's notes recorded and dated during significant contacts with the personal care aide and during supervisory visits to the individual's home;

4. All correspondence to the individual, DMAS, and the designated preauthorization contractor;

5. Reassessments made during the provision of services;

6. Significant contacts made with family/caregivers, physicians, DMAS, the designated preauthorization contractor, formal, informal services providers and all professionals related to the individual's Medicaid services or medical care;

7. All personal care aides' records (DMAS-90). The personal care aide record shall contain:

a. The specific services delivered to the individual by the aide and his responses to this service;

b. The personal care aide's daily arrival and departure times;

c. The aide's weekly comments or observations about the individual, including observations of the individual's physical and emotional condition, daily activities, and responses to services rendered; and

d. The personal care aide's and individual's or responsible caregiver's weekly signatures, including the date, to verify that personal care services have been rendered during that week as documented in the record. An employee of the provider cannot sign for the individual unless he is a family/caregiver of the individual. This family member cannot be the same family member who is providing the service. Signatures, times and dates shall not be placed on the personal care aide record prior to the last date that the services are actually delivered; and

8. All of the individual's progress reports.

12VAC30-120-960. Agency-directed respite care services.

A. This section contains requirements governing the provision of agency-directed respite care services.

B. Agency-directed respite care services are comprised of hands-on care of either a supportive or health-related nature and may include, but are not limited to, assistance with activities of daily living, access to the community, monitoring of self-administration of medications or other medical needs, monitoring health status and physical condition, and personal care services provided in a work environment. Where the individual requires assistance with activities of daily living, and where specified in the plan of care, such supportive services may include assistance with instrumental activities of daily living. This service does not include skilled nursing services with the exception of skilled nursing tasks (e.g., catheterization) that may be delegated pursuant to 18VAC90-20-420 through 18VAC90-20-460.

C. General. Respite care may only be offered to individuals who have a primary caregiver who requires temporary relief to avoid institutionalization of the individual. Respite care services may be provided in the individual's home or place of residence, or a facility licensed as a nursing facility and enrolled in Medicaid. The authorization of respite care (agency-directed and consumer-directed) is limited to a total of ~~720~~ 480 hours per ~~calendar~~ year per individual effective July 1, 2011. Reimbursement shall be made on an hourly basis.

D. Special provider participation conditions. To be approved as a respite care provider with DMAS, the respite care provider shall:

1. Operate from a business office.

2. Have employees who have satisfactory work records, as evidenced by references from prior job experience, including no evidence of abuse, neglect, or exploitation of incapacitated or older adults and children. Providers are responsible for complying with § 32.1-162.9:1 of the Code of Virginia regarding criminal record checks. The criminal record check shall be available for review by DMAS staff who are authorized by the agency to review these files. DMAS will not reimburse the provider for any services provided by an employee who has committed a barrier crime.

3. Employ (or contract with) and directly supervise a registered nurse who will provide ongoing supervision of all respite care aides/LPNs.

a. The registered nurse supervisor shall be currently licensed to practice in the Commonwealth as an RN and have at least two years of related clinical nursing experience, which may include work in an acute care hospital, public health clinic, home health agency, rehabilitation hospital, nursing facility, or as an LPN.

b. Based on continuing evaluations of the aide's/LPN's performance and the individual's needs, the registered nurse supervisor shall identify any insufficiencies in the

aide's/LPN's abilities to function competently and shall provide training as indicated.

c. The registered nurse supervisor shall make an initial home assessment visit on or before the start of care for any individual admitted to respite care.

d. A registered nurse supervisor shall make supervisory visits as often as needed to ensure both quality and appropriateness of services.

(1) When respite care services are received on a routine basis, the minimum acceptable frequency of these supervisory visits shall be every 30 to 90 days dependent on the cognitive status of the individual. If an individual is also receiving personal care services, the respite care RN supervisory visit may coincide with the personal care RN supervisory visits.

(2) When respite care services are not received on a routine basis, but are episodic in nature, a registered nurse supervisor shall not be required to conduct a supervisory visit every 30 to 90 days. Instead, a registered nurse supervisor shall conduct the initial home assessment visit with the aide/LPN on or before the start of care and make a second home visit during the second respite care visit. If an individual is also receiving personal care services, the respite care RN supervisory visit may coincide with the personal care RN supervisory visit.

(3) When respite care services are routine in nature and offered in conjunction with personal care, the RN supervisory visit conducted for personal care services may serve as the registered nurse supervisory visit for respite care. However, the registered nurse supervisor shall document supervision of respite care separately from the personal care documentation. For this purpose, the same individual record can be used with a separate section for respite care documentation.

e. During visits to the individual's home, the registered nurse supervisor shall observe, evaluate, and document the adequacy and appropriateness of respite care services with regard to the individual's current functioning status and medical and social needs. The aide's/LPN's record shall be reviewed along with the individual's or family's satisfaction with the type and amount of services discussed. The registered nurse supervisor shall document in a summary note:

(1) Whether respite care services continue to be appropriate;

(2) Whether the plan of care is adequate to meet the individual's needs or if changes need to be made to the plan of care;

(3) The individual's satisfaction with the services;

(4) Any hospitalization or change in the medical condition or functioning status of the individual;

(5) Other services received by the individual and the amount of the services received; and

(6) The presence or absence of the aide/LPN in the home during the RN supervisory visit.

f. An RN supervisor shall be available to the aide/LPN for conference pertaining to individuals being served by the aide/LPN and shall be available to the aide/LPN by telephone at all times that the aide/LPN is providing services to respite care individuals.

g. If there is a delay in the registered nurse's supervisory visits because the individual is unavailable, the reason for the delay must be documented in the individual's record.

4. Employ and directly supervise aides/LPNs who provide direct care to respite care individuals. Each aide/LPN hired by the provider shall be evaluated by the provider to ensure compliance with qualifications as required by DMAS. Each aide must:

a. Be at least 18 years of age or older;

b. Be physically able to do the work;

c. Be able to read and write in English to the degree necessary to perform the tasks expected;

d. Have completed a minimum of 40 hours of DMAS-approved training consistent with DMAS standards. Prior to assigning an aide to an individual, the provider shall ensure that the aide has satisfactorily completed a training program consistent with DMAS standards; and

e. Be evaluated in his job performance by the registered nurse supervisor.

Respite care aides may not be the parents of minor children who are receiving waiver services or spouses of individuals who are receiving waiver services. Payment may not be made for services furnished by other family members living under the same roof as the individual receiving services unless there is objective written documentation as to why there are no other providers or aides available to provide the care. Family members who are approved to provide paid respite services must meet the qualifications for respite care aides.

5. Employ a licensed practical nurse (LPN) to perform skilled respite care services. Such services shall be reimbursed by DMAS under the following circumstances:

a. The individual has a need for routine skilled care that cannot be provided by unlicensed personnel. These individuals would typically require a skilled level of care if in a nursing facility (e.g., individuals on a ventilator, individuals requiring nasogastric or gastrostomy feedings, etc.);

b. No other individual in the individual's support system is willing and able to supply the skilled component of the individual's care during the caregiver's absence; and

c. The individual is unable to receive skilled nursing visits from any other source that could provide the skilled care usually given by the caregiver.

The provider must document in the individual's record the circumstances that require the provision of services by an LPN. When an LPN is required, the LPN must also provide any of the services normally provided by an aide.

E. Required documentation for individuals' records. The provider shall maintain all records of each individual receiving respite services. These records shall be separated from those of nonhome and community-based care services, such as companion or home health services. These records shall be reviewed periodically by the DMAS staff who are authorized by DMAS to review these files. At a minimum these records shall contain:

1. The most recently updated Long-Term Care Uniform Assessment Instrument, the Medicaid Funded Long-Term Care Service Authorization Form (DMAS-96), the Screening Team Plan of Care for Medicaid-Funded Long-Term Care (DMAS-97), all respite care assessments and plans of care, all aide records (DMAS-90), all LPN skilled respite records (DMAS-90A), all Patient Information Forms (DMAS-122), and all DMAS-101A and DMAS-101B forms, as applicable;

2. The physician's order for services, obtained prior to the service begin date and updated every six months;

3. The initial assessment by a registered nurse completed prior to or on the date services are initiated;

4. Registered nurse supervisor's notes recorded and dated during significant contacts with the care aide and during supervisory visits to the individual's home;

5. All correspondence to the recipient, DMAS, and the designated preauthorization contractor;

6. Reassessments made during the provision of services;

7. Significant contacts made with family, physicians, DMAS, the designated preauthorization contractor, formal and informal services providers, and all professionals related to the individual's Medicaid services or medical care; and

8. All respite care records. The respite care record shall contain:

a. The specific services delivered to the individual by the aide or LPN and his response to this service;

b. The daily arrival and departure times of the aide or LPN for respite care services;

c. Comments or observations recorded weekly about the individual. Aide or LPN comments shall include but not be limited to observation of the individual's physical and emotional condition, daily activities, and the individual's response to services rendered;

d. The signatures of the aide or LPN, and the individual, once each week to verify that respite care services have been rendered. Signature, times, and dates shall not be placed on the aide's record prior to the last date of the week that the services are delivered. If the individual is unable to sign the aide record, it must be documented in his record how or who will sign in his place. An employee of the provider shall not sign for the individual unless he is a family member or legal guardian of the recipient; and

e. All individual progress reports.

Documentation signed by the LPN must be reviewed and signed by the supervising RN.

12VAC30-120-980. Consumer-directed services: personal care and respite services.

A. Service description.

1. Consumer-directed personal care services and respite care services are comprised of hands-on care of either a supportive or health-related nature and may include, but are not limited to, assistance with activities of daily living, access to the community, monitoring of self-administration of medications or other medical needs, monitoring health status and physical condition, and personal care services provided in a work environment. Where the individual requires assistance with activities of daily living, and where specified in the plan of care, such supportive services may include assistance with instrumental activities of daily living. This service does not include skilled nursing services with the exception of skilled nursing tasks (e.g., catheterization) that may be delegated pursuant to 18VAC90-20-420 through 18VAC90-20-460.

2. Consumer-directed respite services are specifically designed to provide temporary, periodic, or routine relief to the unpaid primary caregiver of an individual. This service may be provided in the individual's home or other community settings.

3. DMAS shall either provide for fiscal agent services or contract for the services of a fiscal agent for consumer-directed services. The fiscal agent will be reimbursed by DMAS (if the service is contracted) to perform certain tasks as an agent for the individual/employer who is receiving consumer-directed services. The fiscal agent will handle responsibilities for the individual for employment taxes. The fiscal agent will seek and obtain all necessary authorizations and approvals of the Internal Revenue Services in order to fulfill all of these duties.

4. Individuals choosing consumer-directed services must receive support from a CD services facilitator. This is not a separate waiver service, but is required in conjunction with consumer-directed services. The CD services facilitator is responsible for assessing the individual's particular needs for a requested CD service, assisting in the development of the plan of care, providing training to the individual and family/caregiver on his responsibilities as an employer, and providing ongoing support of the consumer-directed services. The CD services facilitator cannot be the individual, direct service provider, spouse, or parent of the individual who is a minor child, or a family/caregiver employing the aide.

B. Criteria.

1. In order to qualify for consumer-directed personal care services, the individual must demonstrate a need for personal care services as defined in 12VAC30-120-900.

2. Consumer-directed respite services may only be offered to individuals who have an unpaid primary caregiver who requires temporary relief to avoid institutionalization of the individual. Respite services are designed to focus on the need of the unpaid primary caregiver for temporary relief and to help prevent the breakdown of the unpaid primary caregiver due to the physical burden and emotional stress of providing continuous support and care to the individual.

3. DMAS will also pay, consistent with the approved plan of care, for personal care that the personal care aide provides to the enrolled individual to assist him at work or postsecondary school. DMAS will not duplicate services that are required as a reasonable accommodation as a part of the Americans with Disabilities Act (ADA) (42 USC §§ 12131 through 12165) or the Rehabilitation Act of 1973.

a. DMAS or the designated preauthorization contractor will review the individual's needs and the complexity of the disability, as applicable, when determining the services that will be provided to him in the workplace or postsecondary school or both.

b. DMAS will not pay for the personal care aide to assist the enrolled individual with any functions related to the individual completing his job or postsecondary school functions or for supervision time during work or school or both.

4. Individuals who are eligible for consumer-directed services must have, or have a family/caregiver who has, the capability to hire and train their own personal care aides and supervise the aide's performance. If an individual is unable to direct his own care or is under 18 years of age, a family/caregiver may serve as the employer on behalf of the individual.

5. The individual, or if the individual is unable, a family/caregiver, shall be the employer of consumer-directed services and, therefore, shall be responsible for hiring, training, supervising, and firing personal care aides. Specific employer duties include checking references of personal care aides, determining that personal care aides meet basic qualifications, and maintaining copies of timesheets to have available for review by the CD services facilitator and the fiscal agent on a consistent and timely basis. The individual or family/caregiver must have a backup plan for the provision of services in case the aide does not show up for work as expected or terminates employment without prior notice.

C. Service units and limitations.

1. The unit of services for consumer-directed respite services is one hour. ~~Consumer-directed~~ Effective July 1, 2011, consumer-directed respite services are limited to a maximum of ~~720~~ 480 hours per ~~calendar~~ year. Individuals who receive consumer-directed respite services, agency-directed respite services ~~and/or~~ or facility-based respite services, or both, may not receive more than ~~720~~ 480 hours combined, regardless of service delivery method.

2. The unit of service for consumer-directed personal care services is one hour. Effective July 1, 2011, these personal care services shall be limited to 56 hours per week for 52 weeks per year. Individual exceptions may be granted based on criteria established by DMAS.

D. Provider qualifications. In addition to meeting the general conditions and requirements for home and community-based services participating providers as specified in 12VAC30-120-930, the CD services facilitator must meet the following qualifications:

1. To be enrolled as a Medicaid CD services facilitator and maintain provider status, the CD services facilitator shall have sufficient resources to perform the required activities. In addition, the CD services facilitator must have the ability to maintain and retain business and professional records sufficient to fully and accurately document the nature, scope, and details of the services provided.

2. It is preferred that the CD services facilitator possess, at a minimum, an undergraduate degree in a human services field or be a registered nurse currently licensed to practice in the Commonwealth. In addition, it is preferable that the CD services facilitator have at least two years of satisfactory experience in a human services field working with individuals who are disabled or elderly. The CD services facilitator must possess a combination of work experience and relevant education that indicates possession of the following knowledge, skills, and abilities. Such knowledge, skills and abilities must be documented on the CD services facilitator's application form, found in supporting documentation, or be observed during a job

interview. Observations during the interview must be documented. The knowledge, skills, and abilities include:

a. Knowledge of:

(1) Types of functional limitations and health problems that may occur in individuals who are elderly or individuals with disabilities, as well as strategies to reduce limitations and health problems;

(2) Physical care that may be required by individuals who are elderly or individuals with disabilities, such as transferring, bathing techniques, bowel and bladder care, and the approximate time those activities normally take;

(3) Equipment and environmental modifications that may be required by individuals who are elderly or individuals with disabilities that reduce the need for human help and improve safety;

(4) Various long-term care program requirements, including nursing facility and assisted living facility placement criteria, Medicaid waiver services, and other federal, state, and local resources that provide personal care and respite services;

(5) Elderly or Disabled with Consumer-Direction Waiver requirements, as well as the administrative duties for which the services facilitator will be responsible;

(6) How to conduct assessments (including environmental, psychosocial, health, and functional factors) and their uses in services planning;

(7) Interviewing techniques;

(8) The individual's right to make decisions about, direct the provisions of, and control his consumer-directed services, including hiring, training, managing, approving time sheets, and firing an aide;

(9) The principles of human behavior and interpersonal relationships; and

(10) General principles of record documentation.

b. Skills in:

(1) Negotiating with individuals, family/caregivers and service providers;

(2) Assessing, supporting, observing, recording, and reporting behaviors;

(3) Identifying, developing, or providing services to individuals who are elderly or individuals with disabilities; and

(4) Identifying services within the established services system to meet the individual's needs.

c. Abilities to:

(1) Report findings of the assessment or onsite visit, either in writing or an alternative format for individuals who have visual impairments;

(2) Demonstrate a positive regard for individuals and their families;

(3) Be persistent and remain objective;

(4) Work independently, performing position duties under general supervision;

(5) Communicate effectively, orally and in writing; and

(6) Develop a rapport and communicate with individuals from diverse cultural backgrounds.

3. If the CD services facilitator is not a registered nurse, the CD services facilitator must inform the individual's primary health care provider that services are being provided and request consultation as needed.

4. Initiation of services and service monitoring.

a. For consumer-directed services, the CD services facilitator must make an initial comprehensive home visit to collaborate with the individual and family/caregiver to identify the needs, assist in the development of the plan of care with the individual or family/caregiver, and provide employee management training within seven days of the initial visit. The initial comprehensive home visit is done only once per provider upon the individual's entry into CD services. If the individual changes CD services facilitator, the new CD services facilitator must complete a reassessment visit in lieu of a comprehensive visit.

b. After the initial visit, the CD services facilitator will continue to monitor the plan of care on an as-needed basis, but in no event less frequently than quarterly for personal care. The CD services facilitator will review the utilization of consumer-directed respite services, either every six months or upon the use of 300 respite services hours, whichever comes first.

c. A CD services facilitator must conduct face-to-face meetings with the individual or family/caregiver at least every six months for respite services and quarterly for personal care to ensure appropriateness of any consumer-directed services received by the individual.

5. During visits with the individual, the CD services facilitator must observe, evaluate, and consult with the individual or family/caregiver, and document the adequacy and appropriateness of consumer-directed services with regard to the individual's current functioning and cognitive status and medical and social needs. The CD services facilitator's written summary of the visit must include, but is not necessarily limited to:

a. A discussion with the individual or family/caregiver concerning whether the service is adequate to meet the individual's needs;

b. Any suspected abuse, neglect, or exploitation and who it was reported to;

c. Any special tasks performed by the aide and the aide's qualifications to perform these tasks;

d. The individual's or family/caregiver's satisfaction with the service;

e. Any hospitalization or change in medical condition, functioning, or cognitive status; and

f. The presence or absence of the aide in the home during the CD services facilitator's visit.

6. The CD services facilitator must be available to the individual or family/caregiver by telephone.

7. The CD services facilitator must request a criminal record check and a sex offender record check pertaining to the aide on behalf of the individual and report findings of these records checks to the individual or the family/caregiver and the program's fiscal agent. If the individual is a minor, the aide must also be screened through the DSS Child Protective Services Central Registry. The criminal record check and DSS Child Protective Services Registry finding must be requested by the CD services facilitator prior to beginning CD services. Aides will not be reimbursed for services provided to the individual effective on the date that the criminal record check confirms an aide has been found to have been convicted of a crime as described in § 32.1-162.9:1 of the Code of Virginia or if the aide has a confirmed record on the DSS Child Protective Services Central Registry.

8. The CD services facilitator shall review copies of timesheets during the face-to-face visits to ensure that the number of plan of care-approved hours are being provided and are not exceeded. If discrepancies are identified, the CD services facilitator must discuss these with the individual or family/caregiver to resolve discrepancies and must notify the fiscal agent.

9. The CD services facilitator must maintain records of each individual. At a minimum these records must contain:

a. Results of the initial comprehensive home visit completed prior to or on the date services are initiated and subsequent reassessments and changes to the supporting documentation;

b. The personal care plan of care goals, objectives, and activities must be reviewed by the provider quarterly, annually, and more often as needed, and modified as appropriate. Respite plan of care goals, objectives, and activities must be reviewed by the provider annually and every six months or when ~~300~~ 240 service hours have been used. For the annual review and in cases where the plan of care is modified, the plan of care must be reviewed with the individual;

c. CD services facilitator's dated notes documenting any contacts with the individual or family/caregiver and visits to the individual's home;

d. All correspondence to and from the individual, the designated preauthorization contractor, and DMAS;

e. Records of contacts made with the individual, family/caregiver, physicians, formal and informal service providers, and all professionals concerning the individual;

f. All training provided to the aides on behalf of the individual or family/caregiver;

g. All employee management training provided to the individual or family/caregiver, including the individual's or family/caregiver's receipt of training on their responsibility for the accuracy of the aide's timesheets;

h. All documents signed by the individual or the individual's family/caregiver that acknowledge the responsibilities as the employer; and

i. All copies of the completed Uniform Assessment Instrument (UAI), the Medicaid Funded Long-Term Care Service Authorization Form (DMAS-96), the Screening Team Plan of Care form (DMAS-97), all Consumer-Directed Personal Assistance Plans of Care forms (DMAS-97B), all Patient Information Forms (DMAS-122), the DMAS-95 Addendum, the Outline and Checklist for Consumer-Directed Recipient Comprehensive Training, and the Services Agreement Between the Consumer and the Services Facilitator.

10. For consumer-directed personal care and consumer-directed respite services, individuals or family/caregivers will hire their own personal care aides and manage and supervise their performance. The aide must meet the following requirements:

a. Be 18 years of age or older;

b. Have the required skills to perform consumer-directed services as specified in the individual's supporting documentation;

c. Be able to read and write in English to the degree necessary to perform the tasks expected;

d. Possess basic math, reading, and writing skills;

e. Possess a valid Social Security number;

f. Submit to a criminal records check and, if the individual is a minor, consent to a search of the DSS Child Protective Services Central Registry. The aide will not be compensated for services provided to the

individual if either of these records checks verifies the aide has been convicted of crimes described in § 32.1-162.9:1 of the Code of Virginia or if the aide has a founded complaint confirmed by the DSS Child Protective Services Central Registry;

g. Be willing to attend training at the individual's or family/caregiver's request;

h. Understand and agree to comply with the DMAS Elderly or Disabled with Consumer Direction Waiver requirements; and

i. Receive periodic tuberculosis (TB) screening.

11. Aides may not be the parents of minor children who are receiving waiver services or the spouse of the indiviudals who are receiving waiver services or the family/caregivers that are directing the individual's care. Payment may not be made for services furnished by other family/caregivers living under the same roof as the individual being served unless there is objective written documentation as to why there are no other providers available to provide the care.

12. Family/caregivers who are reimbursed to provide consumer-directed services must meet the aide qualifications.

13. If the individual is consistently unable to hire and retain the employment of a personal care aide to provide consumer-directed personal care or respite services, the CD services facilitator will make arrangements to have the services transferred to an agency-directed services provider of the individual's choice or to discuss with the individual or family/caregiver other service options.

14. The CD services facilitator is required to submit to DMAS biannually, for every individual, an individual progress report, the most recently updated UAI, and any monthly visit/progress reports. This information is used to assess the individual's ongoing need for Medicaid-funded long-term care and appropriateness and adequacy of services rendered.

D. Individual responsibilities.

1. The individual must be authorized for consumer-directed services and successfully complete management training performed by the CD services facilitator before the individual can hire a personal care aide for Medicaid reimbursement. Individuals who are eligible for consumer-directed services must have the capability to hire and train their own personal care aides and supervise aides' performance. Individuals with cognitive impairments who are unable to manage their own care may have a family/caregiver serve as the employer on behalf of the individual.

2. Individuals will acknowledge that they will not knowingly continue to accept consumer-directed personal care services when the service is no longer appropriate or necessary for their care needs and will inform the services facilitator. If consumer-directed services continue after services have been terminated by DMAS or the designated preauthorization contractor, the individual will be held liable for employee compensation.

12VAC30-135-200. Agency-directed respite services.

A. Service description.

1. Respite services means services specifically designed to provide a temporary but periodic or routine relief to the primary unpaid caregiver of a client who is in need of specialized supervision due to a SED. Respite services include assistance with or monitoring of personal hygiene, nutritional support, safety, and environmental maintenance authorized as either episodic, temporary relief, or as a routine periodic relief of the caregiver.

2. Respite services do not include either practical or professional nursing services or those practices regulated in Chapters 30 (§ 54.1-3000 et seq.) and 34 (§ 54.1-3400 et seq.) of Title 54.1 of the Code of Virginia, as appropriate. This service does not include skilled nursing services with the exception of skilled nursing tasks that may be delegated pursuant to 18VAC90-20-420 through 18VAC90-20-460.

B. Criteria.

1. Respite services may only be offered to clients who have an unpaid primary caregiver living in the home who requires temporary relief to avoid institutionalization of the client. Respite services are designed to focus on the need of the caregiver for temporary relief.

2. Respite services are supports for the family or other unpaid primary caregiver of a client. These services are furnished on a short-term basis because of the absence or need for relief of those unpaid caregivers normally providing the care for the clients.

C. Service units and service limitations.

1. ~~Respite~~ Effective July 1, 2011, respite services shall be limited to a maximum of ~~720~~ 480 hours per ~~calendar~~ year. Clients who are receiving services through both the agency-directed and CD models shall not exceed ~~720~~ 480 hours per ~~calendar~~ year combined.

2. The unit of service is one hour.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based participating providers as specified in 12VAC30-135-120 and 12VAC30-135-160, respite services providers must meet additional provider requirements:

1. Services shall be provided by:

a. A DMAS respite services provider; a DMHMRSAS-licensed residential services provider; or by a DMHMRSAS-licensed respite services provider or a DSS-approved foster care home-for-children provider.

b. For DMAS-enrolled respite services providers, the provider must employ or subcontract with a QMHP or LMHP to supervise all assistants. The supervisor must meet DMAS qualifications.

2. The QMHP/LMHP supervisor must make a home visit to conduct an initial assessment prior to the start of services for all clients requesting respite services. The supervisor must also perform any subsequent reassessments or changes to the ISP.

3. The QMHP/LMHP supervisor must make supervisory home visits as often as needed to ensure both quality and appropriateness of services. The minimum frequency of these visits is every 30 to 90 days.

a. When respite services are received on a routine basis, the minimum acceptable frequency of these supervisory visits shall be every 30 to 90 days, depending on the needs of the client.

b. When respite services are not received on a routine basis, but are episodic in nature, the supervisor is not required to conduct a supervisory visit every 30 to 90 days. Instead, the QMHP/LMHP supervisor must conduct the initial home visit with the respite care assistant immediately preceding the start of services and make a second home visit within the respite services period.

4. Based on continuing evaluations of the assistant's performance and client's needs, the QMHP/LMHP supervisor shall identify any gaps in the assistant's ability to function competently and shall provide training as indicated.

5 The QMHP/LMHP supervisor must document in a summary note:

a. Whether respite services continue to be appropriate;

b. Whether the ISP is adequate to meet the client's needs or if changes need to be made;

c. The client's and family/caregiver's satisfaction with the service;

d. Any hospitalization or change in medical condition or functioning status;

e. Other services received and the amount; and

f. The presence or absence of the assistant in the home during the visit.

6. Qualification of assistants. The assistant must complete a training curriculum consistent with DMAS requirements. Prior to assigning an assistant to a client, the provider must obtain documentation that the assistant has satisfactorily completed a training program consistent with DMAS' requirements. DMAS requirements may be met in one of two ways:

a. Registration as a certified nurse aide; or

b. Graduation from an approved educational curriculum that offers certificates qualifying the student as a nursing assistant, home health aide, or meeting the paraprofessional criteria as established by 12VAC30-50-226.

E. Required documentation for the client's records. The provider must maintain all records of each client receiving services. These records must be separated from those of other nonwaiver services, such as home health services. These records will be reviewed periodically by DMAS staff. At a minimum these records must contain:

1. An initial assessment completed by the QMHP/LMHP supervisor prior to or on the date services are initiated~~;~~ .

2. Reassessments and any changes to the ISP made during the provision of services by the supervisor.

3. The most recent ISP and supporting documentaion that contains, at a minimum, the following elements:

a. The client's strengths, desired outcomes, and required or desired supports;

b. The client's and family's/caregiver's goals and objectives to meet the identified outcomes;

c. Services to be rendered and the frequency of services to accomplish the goals and objectives; and

d. The provider staff responsible for the overall coordination and integration of the services specified in the ISP.

4. The ISP goals, objectives, and activities must be reviewed by the supervisor quarterly, annually, and more often as needed and modified as appropriate. The results of these reviews must be submitted to the case manager. For the annual review and in cases where the ISP is modified, the ISP must be reviewed with the client and family/caregiver.

5. The QMHP/LMHP supervisor's notes recorded and dated during significant contacts with the respite services assistant and during supervisory visits to the client's home. The written summary of the supervision visits must include:

a. Whether services continue to be appropriate and whether the ISP is adequate to meet the needs or if changes are indicated in the ISP;

b. Any suspected abuse, neglect, or exploitation and to whom it was reported;

c. Any special tasks performed by the assistant and the assistant's qualifications to perform these tasks;

d. The client's and family/caregiver's satisfaction with the service;

e. Any hospitalization or change in medical condition or functioning status;

f. Other services received and their amount; and

g. The presence or absence of the assistant in the home during the supervisor's visit.

6. All correspondence to the client, family/caregiver, case manager, DMAS, DMHMRSAS, and CSA;

7. Significant contacts made with the client, family/caregivers, physicians, DMAS and others involved in the care of the client;

8. The assistant record must contain:

a. The specific services delivered to the client by the assistant, dated the day of service delivery, and the client's responses;

b. The assistant's arrival and departure times;

c. The assistant's weekly comments or observations about the client to include observations of the client's physical and emotional condition, daily activities, and responses to services rendered; and

d. The assistant's, client's and family/caregiver's weekly signatures with dates recorded on the last day of service delivery for any given week to verify that services during that week have been rendered.

e. Signatures, times, and dates shall not be placed on the assistant record prior to the last date of the week that the services are delivered.

9. All DMAS quality management review forms.

12VAC30-135-220. Consumer-directed companion and respite services.

A. Companion services.

1. Service description. Companion services provide assistance with skill development and with understanding family interaction, behavioral interventions for support and safety, nonmedical care, nonmedical transportation, community integration, and rewarding appropriate behaviors. This service is available through both a consumer-directed (CD) and agency-directed delivery approach and shall not exceed eight hours in one day. These services include, but are not limited to, nonmedical care, socialization, or support to a client as well as supervision or monitoring to those clients who require the physical presence of an aide to ensure their safety during times when no other supportive individuals are available. This service is provided in accordance with a therapeutic goal in the ISP and is not purely diversional in nature.

2. Criteria.

a. The inclusion of companion services in the ISP is appropriate only when the client cannot be left alone at any time due to the SED. The provision of companion services does not entail hands-on care.

b. Companion services shall not be covered if required only because the client does not have a telephone in the home or because the client does not speak English.

c. There must be a clear and present danger to the client as a result of being left unsupervised. Companion services cannot be authorized for clients whose only need for companion services is for assistance exiting the home in the event of an emergency.

3. Service units and service limitations.

a. The amount of companion service time included in the ISP must be no more than eight hours per day, either separately or in any combination of CD or agency-directed companion services.

b. The hours authorized are based on individual need. No more than three unrelated individuals who are receiving waiver services and live in the same home are permitted to share the authorized work hours of the same companion.

c. Companion services may be authorized for family/caregivers to sleep either during the day or during the night when the client cannot be left alone at any time due to the client's condition. Companion aide services must be necessary to ensure the client's safety if the client cannot be left unsupervised due to health and safety concerns.

d. Companion services can be authorized when no one else is in the home who is competent to monitor the client for safety.

4. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based participating providers as specified in 12VAC30-135-120 and 12VAC30-135-160, companion service providers must meet the following qualifications:

a. General companion qualifications. Companions must meet the following requirements:

(1) Be at least 18 years of age;

(2) Have the required skills to perform CD services as specified in the client's ISP;

(3) Possess basic reading, writing, and math skills;

(4) Be capable of following a care plan with minimal supervision;

(5) Submit to a criminal history record check within 15 days from the date of employment and, if the client is a minor, the Child Protective Services Central Registry. The companion will not be compensated for services provided to the client if the records check verifies the companion has been convicted of crimes described in § 32.1-162.9:1 or 37.2-416 of the Code of Virginia; or if the companion has a complaint confirmed by the DSS Child Protective Services Central Registry;

(6) Possess a valid social security number;

(7) Be willing to attend training at the client's and family/caregiver's request;

(8) Receive an annual tuberculosis (TB) screening; and

(9) Understand and agree to comply with the DMAS CMH waiver requirements as described in DMAS guidance documents.

b. Companions shall not be spouses, parents or caregivers. Payment will not be made for services furnished by other family members unless there is objective written documentation as to why there are no other providers available to provide the care. Medicaid-reimbursed companion services shall not be provided by adult foster care providers or any other paid (regardless of the payment source) caregivers for a client residing in that home.

c. Family/caregivers who are reimbursed to provide companion services must meet the companion qualifications stated above.

d. Retention, hiring, and substitution of companions. Upon the client's request, the CD services facilitator shall provide the client or family/caregiver with a list of persons on the assistant registry who can provide temporary assistance until the assistant returns or the client is able to select and hire a new assistant. If a client or family/legal guardian is consistently unable to hire and retain the employment of an assistant to provide CD companion services, the services facilitator must contact the case manager and DMAS to transfer the client, at the client's choice, to a provider that provides Medicaid-funded agency-directed companion services. The CD services facilitator will make arrangements with the case manager to have the client transferred.

B. Respite services.

1. Service description. Respite services include assistance with or monitoring of personal hygiene, nutritional support, safety, and environmental maintenance authorized as either episodic, temporary relief, or as a routine periodic relief of the caregiver. For the purposes of this section, an assistant refers to the individual providing CD respite.

2. Criteria.

a. CD respite services may only be offered to clients who have a primary unpaid caregiver living in the home who requires temporary relief to avoid institutionalization of the client, and it is designed to focus on the need of the caregiver for temporary relief.

b. The inclusion of respite services in the ISP is appropriate only when the client cannot be left unsupervised due to the mental health condition at any time.

3. Service units and service limitations.

a. Effective July 1, 2011, CD respite services are limited to a maximum of ~~720~~ 480 hours per ~~calendar~~ year. Clients who are receiving services through both the agency-directed and CD models shall not exceed ~~720~~ 480 hours per ~~calendar~~ year combined.

b. Clients can receive CD respite services and in-home residential support services in their CSPs but cannot receive these services simultaneously.

c. For CD respite services, clients and family/legal guardian, as appropriate, will hire their own assistants and manage and supervise the assistant's performance.

4. Provider requirements.

a. The assistant must meet the following requirements:

(1) Be at least 18 years of age;

(2) Have the required skills to perform CD services as specified in the client's ISP;

(3) Possess basic reading, writing and math skills;

(4) Be capable of following a care plan with minimal supervision;

(5) Submit to a criminal history record check within 15 days from the date of employment, and if the client is a minor, the Child Protective Services Central Registry. The assistant will not be compensated for services provided to the client if the records check verifies the assistant has been convicted of crimes described in § 32.1-162.9:1 or 37.2-416 of the Code of Virginia or if the assistant has a complaint confirmed by the DSS Child Protective Services Central Registry;

(6) Possess a valid social security number;

(7) Be willing to attend training at the client's and family/caregiver's request;

(8) Receive periodic TB screening; and

(9) Understand and agree to comply with the DMAS CMH waiver requirements~~;~~ .

b. Assistants cannot be spouses, parents of minor children, or legally responsible relatives. Payment will not be made for services furnished by other family members unless there is objective written documentation as to why there are no other providers available to provide the care.

c. Family/caregivers who are reimbursed to provide respite services must meet the assistant qualifications.

d. Retention, hiring, and substitution of assistants. Upon the client's request, the CD services facilitation provider shall provide the client or family/legal guardian with a list of persons on the assistant registry who can provide temporary assistance until the assistant returns or the client is able to select and hire a new assistant. If a client is consistently unable to hire and retain the employment of an assistant to provide CD respite services, the CD services facilitator must contact the case manager and DMAS to transfer the client, at the client's choice, to a provider that provides Medicaid-funded agency-directed respite services. The CD services facilitator will make arrangements with the case manager to have the client transferred.

C. Service facilitation.

1. Clients choosing the CD option must receive support from a CD services facilitator and meet requirements for consumer direction as described in these regulations.

2. DMAS shall contract for the services of a Fiscal Management Service agent for CD companion and respite services. The FMS agent will be reimbursed by DMAS to perform certain tasks as an agent for the client/family/caregiver/employer who is receiving CD services. The FMS agent will handle the responsibilities for the client/family/caregiver/employer for employment taxes. The FMS agent will seek and obtain all necessary authorizations and approvals of the Internal Revenue Services in order to fulfill all of these duties.

3. If a client is unable to direct his own care or is under 18 years of age, a family/legal guardian may serve as the employer on behalf of the client. Specific employer duties include checking of references of assistants/companions, determining that assistants/companions meet basic qualifications, training assistants/companions, supervising the assistant's/companion's performance, and submitting timesheets to the FMS agent on a consistent and timely basis. There must be a back-up plan in case the assistant/companion does not show up for work as expected or terminates employment without prior notice. This is the responsibility of the client or family/legal guardian to establish.

4. Clients or family/legal guardians, as appropriate, choosing the CD model of service delivery must receive support from a CD services facilitator. This is not a separate waiver service, but is required in conjunction with CD respite and companion services. The CD services facilitator is responsible for assessing the client's particular needs for a requested CD service, assisting in the development of the ISP, providing training to the family/legal guardian on his responsibilities as an employer, and providing ongoing support of the CD model of services. The CD services facilitator cannot be the client, the client's case manager, direct service provider, spouse, parent or legally responsible party of the client who is a minor child, or a family/legal guardian employing the assistant/companion. If a client enrolled in CD services has a lapse in services for more than 90 consecutive days, DMAS must be notified and the CD services will be discontinued.

5. Either DMAS or its contractor shall provide the FMS for CD companion and respite services. The FMS agent will be reimbursed by DMAS to perform certain tasks as an agent for the client/employer who is receiving CD services. The FMS agent will handle the responsibilities of employment taxes for the client. The FMS agent will seek and obtain all necessary authorizations and approvals of the Internal Revenue Services in order to fulfill all of these duties.

6. CD services facilitator qualifications. In addition to meeting the general conditions and requirements for home and community-based services participating providers as specified in 12VAC30-135-120 and 12VAC30-135-160, the CD services facilitator must meet the following qualifications:

a. To be enrolled as a Medicaid CD services facilitator and maintain provider status, the CD services facilitator must operate from a physical business office and employ sufficient qualified staff to perform the needed ISP development and monitoring, reassessments, service coordination, and support activities as required. In addition, the CD services facilitator must have the ability to maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the services provided.

b. It is preferred that employees of the CD services facilitator possess a minimum of an undergraduate degree in a human services field or be a QMHP. In addition, it is preferable that the CD services facilitator have two years of satisfactory experience in the human services field working with persons with SED. The CD services facilitator must possess a combination of work experience and relevant education that indicates possession of the following knowledge, skills, and abilities. Such knowledge, skills and abilities must be

documented on the application form, found in supporting documentation, or be observed during the job interview. Observations during the interview must be documented. The knowledge, skills, and abilities include:

(1) Knowledge of:

(a) Types of functional limitations and health problems that may occur in clients with SED, or clients with other disabilities, as well as strategies to reduce limitations and health problems;

(b) Equipment and environmental modifications that may be required by clients with SED that reduce the need for human help and improve safety;

(c) Community-based and other services, including PRTF placement criteria, Medicaid waiver services, and other federal, state, and local resources that provide respite and companion services;

(d) CMH Waiver requirements, as well as the administrative duties for which the services facilitator will be responsible;

(e) CMH Waiver requirements, as well as the administrative duties for which the client and family/caregiver will be responsible;

(f) Conducting assessments (including environmental, psychosocial, health, and functional factors) and their uses in care planning;

(g) Interviewing techniques;

(h) The client's and family/legal guardian's right to make decisions about, direct the provisions of, and control his CD respite and companion services, including hiring, training, managing, approving time sheets, and firing an assistant/companion;

(i) The principles of human behavior and interpersonal relationships; and

(j) General principles of record documentation.

(2) Skills in:

(a) Negotiating with clients, family/caregivers and service providers;

(b) Assessing, supporting, observing, recording, and reporting behaviors;

(c) Identifying, developing, or providing services to clients with SED; and

(d) Identifying services within the established services system to meet the client's needs.

(3) Abilities to:

(a) Report findings of the assessment or onsite visit, either in writing or an alternative format for clients who have visual impairments;

(b) Demonstrate a positive regard for clients and their families;

(c) Be persistent and remain objective;

(d) Work independently, performing position duties under general supervision;

(e) Communicate effectively, orally and in writing; and

(f) Develop a rapport and communicate with persons from diverse cultural backgrounds.

c. If the CD services facilitator is not a QMHP, the CD services facilitator must have QMHP consulting services available, either by a staffing arrangement or through a contracted consulting arrangement. The QMHP consultant is to be available as needed to consult with clients and CD services facilitators on issues related to the needs of the client.

7. Initiation of services and service monitoring.

a. The CD services facilitator must make an initial comprehensive home visit to collaborate with the client and family/caregiver to identify needs, assist in the development of the ISP with the client and provide employee management training. The initial comprehensive home visit is done only once upon the client's entry into the CD model of service regardless of the number or type of CD services that a client chooses to receive. If a client changes CD services facilitators, the new CD services facilitator must complete and bill for a reassessment visit in lieu of an initial comprehensive visit.

b. After the initial visit, the CD services facilitator will periodically review the utilization of companion services at a minimum of every six months or, for respite services, either every six months or upon the use of 300 respite service hours, whichever comes first.

c. A reassessment of the client's level-of-care will occur six months after initial entry into the program, and subsequent reevaluations will occur at a minimum of every six months. During visits to the client's home, the CD services facilitator must observe, evaluate, and consult with the client and family/caregiver and document the adequacy and appropriateness of CD services with regard to the client's current functioning and cognitive status, medical, and social needs. The CD services facilitator's summary must include, but not necessarily be limited to:

(1) Whether CD respite services continue to be appropriate and medically necessary to prevent institutionalization;

(2) Whether the service is adequate to meet the client's needs;

(3) Any special tasks performed by the assistant/companion and the assistant's/companion's qualifications to perform these tasks;

(4) Client's or family/caregiver's satisfaction with the service;

(5) Hospitalization or change in medical condition, functioning, or cognitive status;

(6) Other services received and their amount; and

(7) The presence or absence of the companion/assistant in the home during the CD services facilitator's visit.

d. A face-to-face meeting with the client must be conducted at least every six months to reassess the client's needs and to ensure appropriateness of any CD services received by the client.

e. The CD services facilitator must be available to the client and family/caregiver by telephone.

f. The CD services facilitator must submit a criminal record check pertaining to the assistant/companion on behalf of the client and report findings of the criminal record check to the client and the program's FMS agent. If the client is a minor, the assistant/companion must also be screened through the DSS Child Protective Services Central Registry. Assistants/companions will not be reimbursed for services provided to the client effective the date that the criminal record check confirms an assistant/companion was convicted of a barrier crime or if the assistant/companion has a founded complaint on record in the DSS Child Protective Services Central Registry. The criminal record check and DSS Child Protective Services Central Registry finding must be requested by the CD services facilitator within 15 calendar days of employment. The services facilitator must maintain evidence that a criminal record check was obtained and must make such evidence available for DMAS review.

g. The CD services facilitator shall review and verify bi-weekly timesheets signed by the family/caregiver and the assistant/companion during the face-to-face visits or more often as needed to ensure that the number of ISP-approved hours is not exceeded. If discrepancies are identified, the CD services facilitator must discuss these with the client to resolve discrepancies and must notify the FMS agent. If the client is consistently identified as having discrepancies in his timesheets, the CD services facilitator must contact the case manager to resolve the situation. The CD services facilitator cannot verify timesheets for assistants/companions who have been convicted of a barrier crime or who have a founded complaint on record in the DSS Child Protective Services Registry and must notify the FMS agent.

h. The CD services facilitator must maintain records of each client as described in 12VAC30-135-120 and 12VAC30-135-160.

i. If a client/family/legal guardian is consistently unable to hire and retain the employment of an assistant/companion to provide CD respite or companion services, the CD services facilitator will make arrangements with the case manager to have the services transferred to an agency-directed services provider or to discuss with the client/family/caregiver other service options.

j. The family/legal guardian or client, as appropriate, must hire and train the assistants or companions and supervise the assistant's or companion's performance. The hours authorized are based on individual need.

8. Responsibilities as employer. The client or family/legal guardian, as appropriate, shall be the employer in this service and responsible for hiring, training, supervising, and firing assistants and companions. Specific duties include checking references of assistants/companions, determining that assistants/companions meet basic qualifications, training assistants/companions, supervising the assistant's/companion's performance, and submitting timesheets to the CD services facilitator and FMS agent on a consistent and timely basis. The client must have an emergency back-up plan in case the assistant/companion does not show up for work as expected or terminates employment without prior notice.

9. Required documentation in client's records. The CD services facilitator must maintain all records of each client. At a minimum these records must contain:

a. All copies of the ISP and all supporting documentation.

b. All DMAS quality management review forms.

c. CD services facilitator's notes contemporaneously recorded and dated during any contacts with the client and family/caregiver and during visits to the client's home.

d. All correspondence to the client, family/caregiver and to DMAS.

e. Reassessments made during the provision of services.

f. Records of contacts made with family/caregivers, physicians, DMAS, formal and informal service providers, and others involved in the care of the child.

g. All training provided to the assistant/companion or assistants/companions on behalf of the client.

h. All management training provided to the client or family/caregiver including the client's or family/caregiver's responsibility for the accuracy of the timesheets.

i. All documents signed by the client or family/caregiver that acknowledge the responsibilities of the services.

VA.R. Doc. No. R11-2771; Filed May 3, 2011, 4:46 p.m.

TITLE 14. INSURANCE

STATE CORPORATION COMMISSION

Proposed Regulation

REGISTRAR'S NOTICE: The State Corporation Commission is exempt from the Administrative Process Act in accordance with § 2.2-4002 A 2 of the Code of Virginia, which exempts courts, any agency of the Supreme Court, and any agency that by the Constitution is expressly granted any of the powers of a court of record.

Titles of Regulations: **14VAC5-215. Rules Governing Independent External Review of Final Adverse Utilization Review Decisions (amending 14VAC5-215-10).**

14VAC5-216. Rules Governing Internal Appeal and External Review (adding 14VAC5-216-10 through 14VAC5-216-130).

Statutory Authority: §§ 12.1-13 and 38.2-223 of the Code of Virginia.

Public Hearing Information: A public hearing will be scheduled upon request.

Public Comment Deadline: June 1, 2011.

Agency Contact: Julie Blauvelt, Senior Insurance Market Examiner, Bureau of Insurance, State Corporation Commission, P.O. Box 1157, Richmond, VA 23218, telephone (804) 371-9865, FAX (804) 371-9944, or email julie.blauvelt@scc.virginia.gov.

Summary:

The proposed regulatory action (i) amends 14VAC5-215-10 by limiting the chapter's application to final adverse decisions made before or on June 30, 2011, and (ii) adds a new chapter, 14VAC5-216, Rules Governing Internal Appeal and External Review, to conform the state's external review program with the Uniform Health Carrier External Review Model Act, prepared by the National Association of Insurance Commissioners, as required by the federal Patient Protection and Affordable Care Act. The proposed rules clarify and implement the provisions of Chapter 788 of the 2011 Acts of Assembly which become effective on July 1, 2011, and conform Virginia's internal appeal and external review processes to meet the federal requirements.

Specifically, the proposed rules (i) contain provisions that apply the internal appeal and external review requirements to all health carriers, unless specifically excepted; (ii) set forth guidelines and standards for an internal appeal process that is in conformity with federal Department of Labor regulations that provide for a full and fair review of any adverse benefit determination; and (iii) provide for urgent care appeals, concurrent review decisions, and notification requirements. Although the external review process is outlined in Chapter 35.1 (38.2-3556 et seq.) of Title 38.2 of the Code of Virginia, the proposed rules clarify these provisions and provide forms for this process.

14VAC5-215-10. Scope and purpose.

A. This chapter shall apply to all utilization review entities as that term is defined in 14VAC5-215-30, the issuer of a covered person's policy or contract of health benefits, and covered persons.

B. This chapter shall not apply to utilization review performed under contract with the federal government for patients eligible for health care services under Title XVIII of the Social Security Act (42 USC § 1395 et seq.), utilization review performed under contract with the federal government for patients eligible for health care services under the TRICARE program (10 USC § 1071 et seq.), or utilization review performed under contract with a plan otherwise exempt from the operation of this chapter pursuant to the Employee Retirement Income Security Act of 1974 (29 USC § 1001 et seq.).

This chapter shall not apply to programs administered by the Department of Medical Assistance Services or under contract with the Department of Medical Assistance Services.

C. The purpose of this chapter is to set forth rules to carry out the provisions of Chapter 59 (§ 38.2-5900 et seq.) of Title 38.2 of the Code of Virginia so as to provide (i) a process for appeals to be made to the Bureau of Insurance to obtain an independent external review of final adverse decisions made by a utilization review entity; (ii) procedures for expedited consideration of appeals in cases of emergency health care; and (iii) standards, credentials, and qualifications for impartial health entities.

D. This chapter shall apply to any final adverse decision made on or before June 30, 2011.

CHAPTER 216
RULES GOVERNING INTERNAL APPEAL AND EXTERNAL REVIEW

Part I
General

14VAC5-216-10. Scope and purpose.

A. This chapter shall apply to all health carriers, except that the provisions of this chapter shall not apply to a policy or certificate that provides coverage only for a specified disease, specified accident or accident-only coverage; credit; disability income; hospital indemnity; long-term care; dental, vision care, or any other limited supplemental benefit or to a Medicare supplement policy of insurance; coverage under a plan through Medicare, Medicaid, or the federal employees health benefits program; self-insured plans except that a self-insured employee welfare benefit plan may elect to use the state external review process; any coverage issued under Chapter 55 of Title 10 of the U.S. Code (TRICARE), and any coverage issued as supplemental to that coverage; any coverage issued as supplemental to liability insurance, workers' compensation or similar insurance; and automobile medical payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group or individual basis.

B. The purpose of this chapter is to set forth rules to carry out the provisions of Chapter 35.1 (§ 38.2-3556 et seq.) of Title 38.2 of the Code of Virginia as well as federal law to provide a health carrier with guidelines to assist with establishing a procedure for an internal appeals process under which there will be a full and fair review of any adverse benefit determination. This chapter also sets forth requirements for the external review process.

C. This chapter shall apply to any adverse benefit determination made on or after July 1, 2011, by any health carrier for a grandfathered or non-grandfathered health benefit plan, as defined by the PPACA.

14VAC5-216-20. Definitions.

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

"Adverse benefit determination" in the context of the internal appeals process means (i) a determination by a health carrier or its designee utilization review entity that, based on the information provided, a request for, a benefit under the health carrier's health benefit plan upon application of any utilization review technique does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the requested benefit; (ii) the denial, reduction, or termination of, or failure to provide or make payment in whole or in part for, a benefit based on a determination by a health carrier or its designee utilization review entity of a covered person's eligibility to participate in the health carrier's health benefit plan; (iii) any review determination that denies, reduces, or terminates or fails to provide or make payment, in whole or in part, for a benefit; (iv) a rescission of coverage determination as defined in § 38.2-3438 of the Code of Virginia; or (v) any decision to deny individual coverage in an initial eligibility determination.

"Adverse determination" in the context of external review means a determination by a health carrier or its designee utilization review entity that an admission, availability of care, continued stay, or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested service or payment for the service is therefore denied, reduced, or terminated.

"Authorized representative" means (i) a person to whom a covered person has given express written consent to represent the covered person; (ii) a person authorized by law to provide substituted consent for a covered person; (iii) a family member of a covered person or the covered person's treating health care professional when the covered person is unable to provide consent; (iv) a health care professional when the covered person's health benefit plan requires that a request for a benefit under the plan be initiated by the health care professional; or (v) in the case of an urgent care internal appeal, a health care professional with knowledge of the covered person's medical condition.

"Clinical peer reviewer" means a practicing health care professional who holds a nonrestricted license in a state, district, or territory of the United States and in the same or similar specialty as typically manages the medical condition, procedure, or treatment under appeal.

"Commission" means the State Corporation Commission.

"Concurrent review" means utilization review conducted during a patient's stay or course of treatment in a facility, the office of a health care professional, or other inpatient or outpatient health care setting.

"Covered person" means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan. For purposes of this chapter with respect to the administration of appeals, references to a covered person include a covered person's authorized representative, if any.

"Emergency services" means those health care services that are rendered after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity,

including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in (i) serious jeopardy to the mental or physical health of the individual, (ii) danger of serious impairment of the individual's bodily functions, (iii) serious dysfunction of any of the individual's bodily organs, or (iv) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

"Final adverse determination" means an adverse determination involving a covered benefit that has been upheld by a health carrier, or its designee utilization review entity, at the completion of the health carrier's internal appeal process.

"Group health plan" means an employee welfare benefit plan (as defined in the Employee Retirement Income Security Act of 1974 (29 USC § 1002(1)), to the extent that the plan provides medical care and including items and services paid for as medical care to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

"Health benefit plan" means a policy, contract, certificate, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. "Health benefit plan" does not include accident only, credit, or disability insurance; coverage of Medicare services or federal employee health plans pursuant to contracts with the United States government; Medicare supplement or long-term care insurance; Medicaid coverage; dental only or vision only insurance; specified disease insurance; hospital indemnity coverage; limited benefit health coverage; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; medical expense and loss of income benefits; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

"Health care professional" means a physician or other health care practitioner licensed, accredited, or certified to perform specified health care services consistent with the laws of the Commonwealth.

"Health carrier" means an entity, subject to the insurance laws and regulations of the Commonwealth or subject to the jurisdiction of the commission, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including an accident and sickness insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or a nonstock corporation offering or administering a health services plan, a hospital services plan, or a medical or surgical services plan, or any other entity providing a plan of health insurance, health benefits, or health care services except as excluded under § 38.2-3557 of the Code of Virginia.

"Independent review organization" means an entity that conducts independent external reviews of adverse determinations and final adverse determinations.

"PPACA" means the Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

"Pre-service claim" means a claim for a benefit under a health benefit plan that requires or allows for approval of the benefit in advance of obtaining the service or treatment.

"Post-service claim" means a claim for a benefit under a health benefit plan for which the service or treatment has been provided to the covered person.

"Self-insured plan" means an "employee welfare benefit plan" that has the meaning set forth in the Employee Retirement Income Security Act of 1974, 29 USC § 1002(1).

"Urgent care appeal" means an appeal for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations (i) could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or (ii) in the opinion of the treating health care professional with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal. An urgent care appeal shall not be available for any post-service claim or retrospective adverse benefit determination.

"Utilization review" means a set of formal techniques designed to monitor the use of or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review.

Part II
Internal Appeal

14VAC5-216-30. General requirements.

A. Each health carrier offering a health benefit plan shall establish and maintain an internal appeals procedure in accordance with this chapter, 29 USC § 2560.503-1, and 45 CFR 147.136 to provide a full and fair review of any adverse benefit determination.

B. As part of each health carrier's health benefit plan and any adverse benefit determination, each health carrier shall provide notice of its available internal appeals procedures (including urgent care appeals), including timeframes for submission of an appeal, the health carrier's review and response. Such notice shall also include the name, address,

and telephone number of the person or organizational unit designated to coordinate the review of the appeal for the health carrier, and contact information for the Bureau of Insurance. If the plan is a managed care health insurance plan (MCHIP), the mailing address, telephone number, and email address for the Office of the Managed Care Ombudsman shall also be included.

C. The internal appeals procedure shall not contain any provision, or be administered in a way that unduly inhibits or hampers the initiation or processing of claims for benefits.

D. The internal appeals procedure shall provide for an authorized representative of a covered person to act on behalf of the covered person in pursuing a benefit claim or appeal of an adverse benefit determination. A health carrier may establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a covered person. In the case of an urgent care appeal, a health care professional shall be permitted to act as the authorized representative of the covered person, in accordance with this chapter.

E. The internal appeals procedure shall contain administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with the provisions of the health benefit plan and, where appropriate, the health benefit plan provisions have been applied consistently with respect to similarly situated covered persons.

14VAC5-216-40. Minimum appeal requirements.

A. Each covered person shall be entitled to a full and fair review of an adverse benefit determination. Within 180 days after the date of receipt of a notice of an adverse benefit determination, a covered person may file an appeal with the health carrier. A health carrier may designate a utilization review entity to coordinate the review. For purposes of this chapter, "health carrier" may also mean its designated utilization review entity.

B. The health carrier shall conduct the appeal in a manner to ensure the independence and impartiality of the individuals involved in reviewing the appeal. In ensuring the independence and impartiality of such individuals, the health carrier shall not make decisions regarding hiring, compensation, termination, promotion, or other similar matters based upon the likelihood that an individual will support the denial of benefits.

C. 1. In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other service is experimental, investigational, or not medically necessary or appropriate, the health carrier shall designate a clinical peer reviewer to review the appeal. The clinical peer reviewer shall not have been involved in any previous adverse benefit determination with respect to the claim.

2. A reviewer of any other type of adverse benefit determination shall be an appropriate person designated by the health carrier. The reviewer of the appeal shall not be the individual who made any previous adverse benefit determination of the subject appeal nor the subordinate of such individual and shall not defer to any prior adverse benefit determination.

D. A full and fair review shall also provide for:

1. The covered person to have an opportunity to submit written comments, documents, records, and other information relating to the appeal for the reviewer or reviewers to consider when reviewing the appeal;

2. Upon request to the health carrier, the covered person to have reasonable access to and free of charge copies of all documents, records, and other information relevant to the covered person's request for benefits (note that any request for diagnosis and treatment codes, in itself, should not be considered to be a request for an internal appeal);

3. An appeal process that takes into account all comments, documents, records, and other information submitted by the covered person relating to the appeal, without regard to whether such information was submitted or considered in the initial benefit determination.

4. The identification of medical or vocational experts whose advice was obtained on behalf of the health benefit plan in connection with a covered person's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

5. An urgent care appeal process.

6. Prior to issuing a final adverse benefit determination, the health carrier to provide free of charge to the covered person any new or additional evidence relied upon or generated by the health carrier or at the direction of the health carrier, in connection with the internal appeal sufficiently in advance of the date the determination is required to be provided to permit the covered person a reasonable opportunity to respond prior to that date.

E. A health carrier shall notify the covered person of the final benefit determination within a reasonable period of time appropriate to the medical circumstances, but not later than the timeframes established in subdivisions 1 and 2 of this subsection.

1. If an internal appeal involves a pre-service claim review request, the health carrier shall notify the covered person of its decision within 30 days after receipt of the appeal. A health carrier may provide a second level of internal appeal for group health plans only, provided that a maximum of

15 days is allowed for a benefit determination and notification from each level of the appeal.

2. If an internal appeal involves a post-service claim review request, the health carrier shall notify the covered person of its decision within 60 days after receipt of the appeal. A health carrier may provide a second level of internal appeal for group health plans only, provided that a maximum of 30 days is allowed for a benefit determination and notification from each level of the appeal.

14VAC5-216-50. Urgent care appeals.

A. The health carrier shall notify the covered person of its initial benefit determination as soon as possible taking into account medical exigencies, but not later than 72 hours after receipt of the request, unless the covered person fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the health benefit plan. In the case of such failure, the health carrier shall notify the covered person as soon as possible, but not later than 24 hours after receipt of the request, of the specific information necessary to complete the claim. The covered person shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours to provide the specified information. The health carrier shall notify the covered person of its benefit determination not later than 48 hours after the earlier of (i) its receipt of the specified information or (ii) the end of the period afforded to the covered person to provide the specified additional information.

B. The notification of an urgent care adverse benefit determination that is based on a medical necessity, appropriateness, health care setting, level of care, effectiveness, experimental or investigational service or treatment, or similar exclusion or limit, shall include a description of the health carrier's urgent care appeal process including any time limits applicable to those procedures and the availability of and procedures for an expedited external review.

C. Upon receipt of an adverse benefit determination, a covered person may submit a request for an urgent care appeal either orally or in writing to the health carrier.

D. All necessary information, including the benefit determination on appeal, shall be transmitted between the health carrier and the covered person by telephone, facsimile, or the most expeditious method available.

E. The health carrier shall notify the covered person and the treating health care professional of its benefit determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of an urgent care appeal.

14VAC5-216-60. Concurrent review decisions.

A. A health carrier shall provide continued coverage pending the outcome of an internal appeal of a concurrent review decision.

B. Any reduction or termination by a health carrier of an approved course of treatment (other than by health benefit plan amendment or termination) to be provided over a period of time or number of treatments shall constitute an adverse benefit determination. The health carrier shall notify the covered person of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the covered person to file an internal appeal and obtain a determination before the benefit is reduced or terminated.

C. Any request by a covered person to extend the course of treatment beyond the period of time or number of treatments that is an urgent care appeal shall be decided as soon as possible, taking into account the medical exigencies. The covered person and the treating health care professional shall be notified of the benefit determination within 72 hours after receipt of the internal appeal.

14VAC5-216-70. Notification requirements.

A. A health carrier shall provide a covered person with written or electronic notification of its benefit determination on appeal. The notification of an adverse benefit determination shall be written in easily understandable language and shall set forth the following:

1. Information sufficient to identify the claim involved with respect to the appeal, including the date of service, the health care provider, and the claim amount;

2. The specific reason or reasons for the adverse benefit determination;

3. Reference to the specific plan provisions on which the adverse benefit determination is made;

4. A statement that the covered person is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the covered person's claim for benefits;

5. A statement indicating whether any additional internal appeals are available or whether the covered person has received a final adverse determination. If internal appeals are available, contact information on where to submit the appeal;

6. A statement describing the external review procedures offered by the health carrier and the covered person's right to obtain information about such procedures and the covered person's right to bring a civil action under § 502(a) of ERISA (29 USC § 1001 et seq.), if applicable; and

7. A statement indicating that the covered person has the right to request an external review if the covered person has not received a final benefit determination within the timeframes provided in 14VAC5-216-40 E, unless the covered person requests or agrees to a delay.

B. In the case of a group health plan, the required notification shall also set forth the following:

1. If an internal rule, guideline, protocol, or other similar criterion (collectively "rule") was relied upon in making the adverse benefit determination, either the specific rule or a statement that such rule was relied upon in making the adverse benefit determination and that a copy of the rule will be provided free of charge to the covered person upon request;

2. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the covered person's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

3. Include a statement indicating that the covered person may have other voluntary alternative dispute resolution options, such as mediation. The covered person should be referred to the appropriate federal or state agency, his plan administrator, or the health carrier, as appropriate.

C. Electronic notification shall be in accordance with the provisions of the Uniform Electronic Transactions Act (§ 59.1-479 et seq. of the Code of Virginia).

Part III
External Review

14VAC5-216-80. Incomplete or ineligible determinations.

A. After the covered person has requested an external review, and if he is notified by the health carrier that the request is incomplete in accordance with § 38.2-3561 B 4 or 38.2-3563 D 6 of the Code of Virginia, the covered person shall have five business days from receipt of such notice to return the requested materials necessary to complete the request to the health carrier. The health carrier shall then have five business days to conduct the preliminary review for eligibility. Notification shall be in accordance with the provisions of § 38.2-3561 C or 38.2-3563 E of the Code of Virginia.

B. If the health carrier determines that a covered person's request for external review is complete but ineligible, the covered person may request that the commission review the ineligibility determination.

1. Within five business days from the date the covered person receives notification from the health carrier, the covered person may request in writing that the commission review the ineligibility determination by the health carrier.

2. Within one business day after receipt of a notification from the covered person, the commission shall notify the health carrier of such request.

3. Within three business days of receipt of the commission's notice to the health carrier, the health carrier shall forward all information and materials used to make the ineligibility determination to the commission.

4. Within five business days of receipt of all materials necessary to make an eligibility determination, the commission shall review the file and make such decision.

5. Within one business day of such decision, the commission shall notify the covered person and the health carrier, and the assigned independent review organization if eligible.

C. If the covered person has requested an expedited external review or an expedited external review of experimental or investigational treatment, and is notified by the health carrier that the request for such expedited external review is incomplete, the covered person shall promptly return the requested materials necessary to complete the request to the health carrier. The health carrier shall then promptly conduct the preliminary review for eligibility.

D. If the health carrier determines that a covered person's request for expedited external review is complete but ineligible, the covered person may promptly request, orally or in writing, that the commission review the ineligibility determination.

1. Upon receipt of an eligibility request from a covered person, the commission shall promptly notify the health carrier of such request.

2. The health carrier shall promptly forward all information and materials used to make the ineligibility determination to the commission.

3. Upon receipt of all information and materials from the health carrier, the commission shall promptly review the file and make an eligibility determination.

4. The commission shall promptly notify the covered person and the health carrier, and the assigned independent review organization if eligible.

E. If the request for a standard external review does not contain sufficient information to allow the commission to send the request to the health carrier, the commission shall have one business day from the date the sufficient information is received to provide notice to the health carrier.

14VAC5-216-90. Expedited external review.

A. If a covered person files a request with the commission for an expedited external review in accordance with § 38.2-

3560 C of the Code of Virginia, the health carrier shall promptly conduct an eligibility determination in accordance with 14VAC5-216-80 prior to review by an independent review organization.

B. When an independent review organization is requested by the commission in accordance with § 38.2-3562 of the Code of Virginia to conduct an expedited external review of an adverse determination under § 38.2-3560 C of the Code of Virginia, the independent review organization shall determine whether the timeframes for sequential completion of the expedited internal appeal and expedited external review (i) could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or (ii) would subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal, as compared to the timeframes for simultaneous completion of the expedited appeal and review. The independent review organization shall promptly make such determination and shall promptly notify the covered person, the health carrier, and the commission.

14VAC5-216-100. Qualifications for independent review organizations.

A. An independent review organization that desires to conduct external reviews for the Commonwealth shall submit an application and $500 application fee using Form 216-E to the commission for review and approval.

B. An independent review organization shall meet all the qualification requirements in § 38.2-3565 of the Code of Virginia.

C. An independent review organization that does not maintain required accreditation status shall provide notice to the commission within 30 days of any change in such status.

14VAC5-216-110. External review reporting requirements.

In accordance with § 38.2-3568 of the Code of Virginia, each health carrier and each independent review organization shall file with the commission a report by April 1 of each calendar year using Form 216-F or 216-G as appropriate.

14VAC5-216-120. Funding of external review.

Failure of a health carrier to timely pay any independent review organization for a completed external review shall be a violation of this section and shall subject the health carrier to penalties imposed under Title 38.2 of the Code of Virginia.

14VAC5-216-130. Self-insured plans.

A. Any self-insured plan whose plan sponsor's headquarters is located in Virginia may choose to utilize the external review processes outlined in Chapter 35.1 (§ 38.2-3556 et seq.) of Title 38.2 of the Code of Virginia. For purposes of Part III of this chapter, "health carrier" shall mean a self-insured plan or its third-party administrator if any, that opts in to the state external review process.

B. A self-insured plan utilizing such external review processes shall notify the commission that it will opt-in to the state external review process by completing Form 216-H. A new form shall be completed for each plan year.

C. A self-insured plan that opts in to the state external review process shall comply with all statutes and regulations pertaining to such process. Plan materials and appropriate denial notices shall contain required information regarding the state external review processes.

D. A self-insured plan that opts into the state external review process but fails to comply with the requirements outlined in this chapter and applicable state statutes pertaining to the external review process may be terminated from use of such process by the commission.

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

FORMS (14VAC5-216)

External Review Request Form, Form 216-A (7/11)

Appointment of Authorized Representative, Form 216-B (7/11)

Physician Certification Expedited External Review Request, Form 216-C (7/11)

Physician Certification Experimental or Investigational Denials, Form 216-D (7/11)

Independent Review Organization Application for Registration, Form 216-E (7/11)

Health Carrier External Review Annual Report Form, Form 216-F (7/11)

Independent Review Organization External Review Annual Report Form, Form 216-G (7/11)

Self-Insured Plan Opt-In to Virginia External Review Process, Form 216-H (7/11)

VA.R. Doc. No. R11-2809; Filed May 3, 2011, 2:32 p.m.

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

VIRGINIA BOARD FOR ASBESTOS, LEAD, AND HOME INSPECTORS

Final Regulation

Title of Regulation: **18VAC15-60. Mold Inspector and Remediator Regulations (adding 18VAC15-60-10 through 18VAC15-60-390).**

Statutory Authority: §§ 54.1-201 and 54.1-501 of the Code of Virginia.

Effective Date: July 1, 2011.

Agency Contact: David Dick, Executive Director, Virginia Board for Asbestos, Lead, Mold, and Home Inspectors, 9960 Mayland Drive, Suite 400, Richmond, VA 23233, telephone (804) 367-8595, FAX (804) 527-4297, or email alhi@dpor.virginia.gov.

Summary:

Chapters 358 and 819 of the 2009 Acts of Assembly charged the board with the creation of a licensure program for the regulation of mold inspectors and mold remediators. This regulation creates the licensure entry requirements, renewal requirements, and standards of practice and conduct for this group of regulants, as well as the disciplinary authority of the board.

Minor changes for clarity and consistency were made to the proposed regulation. Substantive changes made include (i) striking unused words from definitions, (ii) amending how often mold remediator workers must take a refresher course, (iii) adding to the mold remediator supervisor standard for conducting mold remediation activities, (iv) adding to the grounds for disciplinary action, (v) adding to the responsibilities of the licensee, and (vi) adding an amendment to the conflict of interest section.

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

CHAPTER 60
MOLD INSPECTOR AND REMEDIATOR REGULATIONS

Part I
Exemptions from Licensure Requirement

18VAC15-60-10. Exemptions from licensure requirement.

This chapter shall not apply to the following:

1. An individual performing mold remediation in an area in which the mold contamination for the total project affects a total surface area of less than 10 square feet;

2. An owner or the managing agent or employee of an owner performing mold inspections or mold remediation on the owner's residential property, provided such property contains no more than four residential dwelling units;

3. Lab technicians who analyze mold samples as long as it is limited to analysis that is performed solely in a laboratory;

4. An individual performing activities limited to power washing and surface cleaning of a building exterior;

5. Phase [~~1~~ I] environmental site assessments conducted in accordance with ASTM E1527-05 standards that, through the routine conduction of the inspection, indicate the presence of mold. Such inspections shall not include any further investigation of the mold or any other duties of a mold inspector as defined in this chapter;

6. Professional engineers correcting a moisture problem [only]; or

7. Any individual applying chemicals to a wood structure for the sole purpose of controlling wood-destroying pests in compliance with the Virginia Pesticide Control Act (§ 3.2-3900 et seq. of the Code of Virginia).

Part II
Definitions

18VAC15-60-20. Definitions.

Section 54.1-500 of the Code of Virginia provides definitions of the following terms and phrases as used in this chapter:

"Mold" means any living or dead fungi or related products or parts, including spores, hyphae, and spore-producing structures.

"Mold analysis" means the examination of a sample collected during a mold inspection for the purpose of (i) determining the amount or presence of or identifying the genus, species, or functional grouping of any living or dead mold present in the sample or (ii) identifying or determining the amount or presence of any fungal products including, but not limited to, mycotoxins and fungal volatile organic compounds present in the sample.

"Mold inspection" means (i) an inspection, investigation, or survey of a dwelling or other structure to determine the presence of mold; (ii) the development of a mold management plan or mold remediation protocol; or (iii) the collection or analysis of a mold sample.

"Mold inspector" means an individual who has been licensed by the board to perform mold inspections.

"Mold remediation" means cleaning mold from building material surfaces or the removal of contaminated building materials that are unsalvageable and other activities, including applying biocides or antimicrobial compounds and sanitization protocols, intended to prevent future mold contamination.

"Mold remediator" means an individual licensed by the board to perform mold remediation.

"Person" means a corporation, partnership, sole proprietorship, firm, enterprise, franchise, association, or any other individual or entity.

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

"Approved mold training course" means any training course offered by a person who has been approved by the board to provide training for individuals that is required for obtaining an initial license or renewing an existing license as a mold remediator worker, mold remediator supervisor, or mold inspector.

"Approved mold training provider" means a person who has been approved by the board to offer one or more approved mold training courses.

[~~"AIHA" means the American Industrial Hygiene Association.~~]

[~~"ANSI" means the American National Standards Institute.~~]

"Applicant" means an individual seeking licensure that has submitted a fully executed application or any person seeking board approval to offer mold training courses.

"Application" means a board-prescribed form submitted with the appropriate fee and other required documentation including, but not limited to, references, employment verification, degree verification, and verification of examination and licensure, certification, or registration.

[~~"Approval letter" means a written notice confirming an individual applicant's licensure or a person's approval by the board to offer a specific approved mold training course.~~]

"ASTM" means the American Society for Testing and Materials.

"Department" means the Virginia Department of Professional and Occupational Regulation.

[~~"Direct supervisor" means a licensed mold remediator supervisor who undertakes to supervise the activities of a licensed mold remediator worker and shall be physically present on the premises at all times while any licensed mold remediator worker under his supervision is engaged in the activities involving mold remediation.~~]

"Discipline" means any one of the specific licenses of mold remediator worker, mold remediator supervisor, or mold inspector.

[~~"Endorsement" means the recognition of licenses or certificates issued by other states, the District of Columbia, or any territory or possession of the United States as permitted by § 54.1-500 et seq. of the Code of Virginia.~~]

"Financial interest" means financial benefit accruing to an individual or to a member of his immediate family. Such interest shall exist by reason of (i) ownership in a business if the ownership exceeds 3.0% of the total equity of the business; (ii) annual gross income that exceeds or may be reasonably anticipated to exceed $1,000 from ownership in real or personal property or a business; (iii) salary, other compensation, fringe benefits, or benefits from the use of property, or any combination of these, paid or provided by a business that exceeds or may be reasonably expected to exceed $1,000 annually; (iv) ownership of real or personal property if the interest exceeds $1,000 in value and excluding ownership in business, income, salary, other compensation, fringe benefits, or benefits from the use of property.

"Guest instructor" means an individual designated by an approved mold training provider's training manager or primary instructor to provide instruction specific to a component of an approved mold training course.

[~~"IAQA" means the Indoor Air Quality Association.~~]

"IEC" means the International Electrotechnical Commission.

[~~"IICRC" means the Institute of Inspection, Cleaning, and Restoration Certification.~~]

"Instructor" means a person designated by an approved mold training provider who instructs one or more approved mold training courses. This definition excludes guest instructors.

"ISO" means the International Organization for Standardization.

"Late renewal" means a period of time during which a regulant may renew a license, certificate, or registration after its expiration date by paying an established fee without having to meet additional requirements.

"Licensed mold inspector" means any individual who meets the requirements of this chapter and is granted a license by the board to conduct mold inspections and mold assessments.

"Licensed mold remediator supervisor" means any individual who meets the requirements of this chapter and is granted a license by the board to conduct and supervise mold remediations.

"Licensed mold remediator worker" means any individual who meets the requirements of this chapter and is granted a license by the board to conduct mold remediations.

"Licensee" means any person as defined by § 54.1-500 of the Code of Virginia who has been issued and holds a currently valid license as a mold remediator worker, mold remediator supervisor, or mold inspector under this chapter.

[~~"NADCA" means the National Air Duct Cleaners Association.~~]

"Phase I Environmental Site Assessment" means an environmental site assessment as defined in ASTM standard E-1527-05.

"Professional engineer" means an individual currently licensed in the Commonwealth of Virginia as a professional engineer.

"Reciprocity" means the recognition of licenses or certificates issued by other states, the District of Columbia, or any territory or possession of the United States as permitted by § [~~54.1-500 et seq.~~ 54.1-103 C] of the Code of Virginia.

"Refresher course" means a specific approved mold training course established by this chapter that must be periodically completed to maintain an individual's license in a single discipline.

"Regulant" means a licensee or an approved mold training provider.

"Renewal" means the process and requirements for periodically approving a regulant to continue practicing.

"Substantially equivalent" means requirements that do not conflict with and are at least as rigorous as this chapter and supporting statutes of the board.

"Training hour" means at least 50 minutes of actual instruction including, but not limited to, time devoted to lecture, learning activities, small group activities, demonstrations, evaluations, or hands-on experience.

Part III
Entry

18VAC15-60-30. Application procedures.

A. All applicants seeking licensure or training course approval shall submit an application with the appropriate fee specified in 18VAC15-60-100. Application shall be made on forms provided by the department.

B. By signing the application or submitting it electronically to the department, the applicant certifies that he has read and understands the board's statutes and regulations.

C. The receipt of an application and the deposit of fees by the board [~~does~~ do] not indicate approval by the board.

D. The board may make further inquiries and investigations with respect to the applicant's qualifications to confirm or amplify information supplied.

E. Applicants will be notified if their application is incomplete. Applicants who fail to complete the process within 12 months of the date of the department's receipt of the original application shall submit a new application and fee.

18VAC15-60-40. Qualifications for licensure - individuals.

A. All applicants shall meet all entry requirements in effect at such time that the application is received by the department.

1. Name. The applicant shall disclose his full legal name.

2. Age. The applicant shall be at least 18 years old.

3. Address. The applicant shall disclose a physical address. A post office box is only acceptable when a physical address is also provided.

4. Specific entry requirements.

a. Mold remediator worker. Each individual applying for an initial mold remediator worker license shall provide proof of successful completion of an initial mold remediator worker course [and all subsequent refresher mold remediator worker courses] from a board-approved mold training provider. The training must have been completed within [~~12~~ 36] months [~~of~~ preceding] the date that the [~~initial license is issued by the board~~ department receives the application].

b. Mold remediator supervisor.

(1) Provide proof of successful completion of an initial mold remediator supervisor course [and all subsequent refresher mold remediator supervisor courses] from a board-approved mold training provider. The training must have been completed within 12 months [~~of~~ preceding] the date that the [~~initial license is issued by the board.~~ department receives the application; and]

(2) Provide proof of one year of experience in a mold or another related environmental remediation field.

c. Mold inspector.

(1) Provide proof of successful completion of an initial mold inspector course [and all subsequent refresher mold inspector courses] from a board-approved mold training provider. The training must have been completed within 12 months [~~of~~ preceding] the date that the [~~initial license is issued by the board.~~ department receives the application; and]

(2) Provide evidence of experience of performing mold inspections including the activities as defined in this chapter. The amount of experience is dependent on the applicant's education as follows:

(a) An applicant with a bachelor's degree in engineering, architecture, industrial hygiene, physical science, [environmental science, biological science,] or a related

field shall have at least six months of experience [~~and~~ or] have completed a minimum of five mold inspections;

(b) An applicant with a two-year associate's degree in engineering, architecture, industrial hygiene, physical science, [environmental science, biological science,] or a related field shall have at least 12 months of experience [~~and~~ or] have completed a minimum of 10 mold inspections; or

(c) An applicant with a high school diploma or equivalent shall have at least 24 months of experience [~~and~~ or] have completed a minimum of 15 mold inspections.

5. Experience verification. Each application for [~~mold remediator worker,~~] mold remediator supervisor [~~,~~] and mold inspector shall include [~~a document signed by the applicant's supervisor~~ documentation] that verifies the applicant's experience [as a mold remediator supervisor or mold inspector as defined in this chapter]. [~~Applicants who are self employed may submit a copy of three completed mold inspections in lieu of a signed document from a supervisor.~~]

6. Education verification. For verification of a high school diploma or equivalent, a copy of the diploma or equivalent must accompany the application. College degrees must be verified by one of the following:

a. Completing an education verification form provided by the board that shall be sent directly from the school to the department; or

b. The board's receipt of official transcripts from the college or university.

7. Training verification. Each application for mold remediator worker, mold remediator supervisor, and mold inspector shall include a copy of the certificate of completion from the initial training course [and all subsequent refresher courses] that shall be specific to the discipline of the license being applied for.

8. Convictions. In accordance with § 54.1-204 of the Code of Virginia, each applicant shall disclose all convictions, in any jurisdiction, of all misdemeanors and felonies. Any plea of nolo contendere shall be considered a conviction for the purpose of this subdivision. The record of a conviction certified or authenticated in such form as to be admissible in evidence under the laws of the jurisdiction where convicted shall be admissible as prima facie evidence of such guilt. The board, at its discretion, may deny licensure to any applicant in accordance with § 54.1-204 of the Code of Virginia.

9. Disciplinary action. Each applicant shall disclose any disciplinary action taken in any jurisdiction, including Virginia, in connection with the applicant's environmental remediation practice including, but not limited to, monetary penalties, fines, suspension, revocation, or surrender of a license in connection with a disciplinary action.

10. Standards of practice and conduct. Applicants shall be in compliance with the standards of practice and conduct set forth in this chapter as applicable at the time of application to the board, while the application is under review by the board, and at all times when the license is in effect.

11. Standing. The applicant shall be in good standing in every jurisdiction where licensed, certified, or authorized and the applicant shall not have had a license, certification, or authorization that was suspended, revoked, or surrendered in connection with any disciplinary action in any jurisdiction prior to applying for licensure in Virginia. The board, at its discretion, may deny licensure or approval to any applicant based on disciplinary action by any jurisdiction.

B. [The board may issue a license to perform mold inspections or mold remediation to any applicant who is certified by a national or state professional mold inspectors or mold remediators association approved by the board, provided that the requirements for the applicant's class of membership in such association at the time such membership was granted are substantially equivalent to the requirements established by the board for all applicants.]

[~~B.~~ C.] Applicants shall have one year from the date of the board's receipt of the application and fee to correct any deficiencies and provide the board with all [~~requisite~~ required] documentation and information. Applications not completed within one year of the date of the board's receipt of the application shall not be further considered by the board for approval. The applicant shall be required to submit to the board a new application and fee.

18VAC15-60-50. Qualifications for approval as a mold training provider.

A. Persons requesting approval as a mold training provider to offer courses to prepare applicants for initial licensure, as well as to prepare applicants and licensees for continued licensure, shall meet the requirements established by this chapter before being granted approval to offer an approved mold training course.

B. A completed application submission shall consist of all information required by this section. Receipt of an application by the department in no way indicates approval of a training course.

C. All training courses shall be discipline-specific. An applicant may seek approval to offer initial or refresher courses in any of the license disciplines as defined in this chapter. A separate application shall be made for each course.

Application shall be made on forms provided by the board and shall include the following:

1. Training provider's business name, physical address, mailing address, and phone number.

2. The course discipline and type, initial or refresher, for which approval is sought.

3. A syllabus that contains the complete training course curriculum.

4. A copy of all training course materials including, but not limited to, student manuals, instructor notebooks, handouts, and training aids.

5. A copy of all examinations used and the corresponding answer sheets.

6. A description of all facilities and equipment to be used for lecture and hands-on training as applicable to the course.

7. A narrative that states how the training course meets the requirements for approval in the following areas:

a. Length of training in hours.

b. Examination content, length, format, and passing score.

c. Topics covered in the training course.

d. Examination administration and integrity.

8. The names of each instructor including resumes, education, training, experience, and certifications relevant to his qualifications to teach the course.

9. An example of a certificate that will be issued to students who successfully complete the approved mold training course. The certificate shall contain the information listed in 18VAC15-60-210.

10. A statement signed by the training manager that certifies that the training course meets the minimum requirements established in this chapter.

D. An approved mold training course must be approved by the board before its certificates shall be accepted by the board to satisfy initial licensure or renewal licensure training requirements. The completion of a mold training course that occurs prior to a course's board approval shall not be used to satisfy board licensure training requirements.

E. Each training course shall be conducted in compliance with this chapter to qualify for and maintain its board approval.

F. Online courses shall not be accepted by the board for approval.

18VAC15-60-60. [~~Licensure or training~~ Training] course approval by reciprocity.

[~~A. The board may issue a license to perform mold inspections or mold remediation to any applicant who is certified by a national or state professional mold inspectors or mold remediators association approved by the board, provided that the requirements for the applicant's class of membership in such association are equal to or exceed the requirements established by the board for all applicants.~~

~~B.~~] The board may grant approval to conduct mold training courses to any applicant who is approved in another state provided that the requirements [at the time] of that state's approval are [~~equal to or exceed~~ substantially equivalent to] the requirements established by the board for mold training course approval.

18VAC15-60-70. Licensure by [~~comity~~ reciprocity].

A person holding a current license, certificate, or registration to engage in the practice of mold inspection or mold remediation issued to the applicant by another state, the District of Columbia, or any territory or possession of the United States based on requirements that [~~do not conflict with and~~] are [~~at least as rigorous as~~ substantially equivalent to] this chapter and supporting statutes of this board that were in effect at the time of original licensure, certification, or registration may be licensed. If the applicant does not meet the requirements for licensure in Virginia, then the applicant shall meet the entry requirements that are current at the time the completed application for [~~comity~~ reciprocity] is received [~~in the board's office~~ by the department].

18VAC15-60-80. Application denial.

The board may refuse initial licensure due to an applicant's failure to comply with entry requirements or for any of the reasons that it may discipline a regulant. The board, at its discretion, may deny licensure to any applicant in accordance with § 54.1-204 of the Code of Virginia. The denial is considered to be a case decision and is subject to appeal under Chapter 40 (§ 2.2-4000 et seq.) of Title 2.2 of the Code of Virginia.

Part IV
Fees

18VAC15-60-90. General fee requirements.

All fees are nonrefundable and shall not be prorated. The date on which the fee is received by the department or its agent will determine whether the fee is on time. Checks or money orders shall be made payable to the Treasurer of Virginia.

18VAC15-60-100. Application fees.

Fee Type	Fee Amount	When Due
Application for mold remediator worker	$25	With application
Application for mold remediator supervisor	$25	With application
Application for mold inspector	$25	With application

18VAC15-60-110. Renewal fees.

Fee Type	Fee Amount	When Due
Renewal of mold remediator worker license	$25	With renewal application
Renewal of mold remediator supervisor license	$25	With renewal application
Renewal of mold inspector license	$25	With renewal application
Late renewal of mold remediator worker license (includes a $25 late renewal fee in addition to the regular $25 renewal fee)	$50	With renewal application
Late renewal of mold remediator supervisor license (includes a $25 late renewal fee in addition to the regular $25 renewal fee)	$50	With renewal application
Late renewal of mold inspector license (includes a $25 late renewal fee in addition to the regular $25 renewal fee)	$50	With renewal application

Part V
Renewal

18VAC15-60-120. Renewal required.

A. Each individual mold remediator worker, mold remediator supervisor, and mold inspector license issued under this chapter shall expire one year from the last day of the month in which it was issued.

B. A fee shall be required for renewal as specified in 18VAC15-60-110.

18VAC15-60-130. Procedures for renewal.

A. The department shall mail a renewal notice to each licensee at the licensee's last known address. The notice shall outline the procedures for renewal and the renewal fee amount. Failure to receive the notice shall not relieve the licensee of the obligation to renew in a timely fashion.

B. Prior to the expiration date shown on the individual's current license, the individual desiring to renew that license shall provide evidence of meeting the refresher training requirement for license renewal as established in 18VAC15-60-140 and the appropriate fee specified in 18VAC15-60-110. The board will only accept mold training courses that were specifically approved by the board at the time that the training was completed. A copy of the training certificate documenting the successful completion of the refresher training for the license discipline being renewed shall accompany the renewal notice and fee.

C. By renewing the license, the regulant is certifying his continued compliance with the Standards of Conduct and Practice in Part X (18VAC15-60-160 et. seq.) of this chapter.

D. Refresher training certificates shall only be used once to renew [~~an individual~~ a mold remediator supervisor or mold inspector, as appropriate,] license.

E. Each license that is not renewed within 30 days of the expiration date on the license shall be subject to late renewal fees as established in 18VAC15-60-110.

F. Any licensee who fails to renew his license within six months after the expiration date on the license shall not be permitted to renew and shall apply as a new applicant and meet all entry requirements as established by this chapter.

18VAC15-60-140. Qualifications for renewal.

A. Licensees desiring to maintain an individual license shall satisfactorily complete a board-approved mold refresher training course not less than once every 12 months for inspector and [~~remediation~~ remediator] supervisor, and not less than once every [~~24~~ 36] months for [~~remediation~~ remediator] worker. It is the licensee's responsibility to ensure the board's receipt of the proof of training completion [, as appropriate,] at the time of license renewal.

B. Refresher training shall be specific to the discipline of the license held.

C. The board shall renew an individual license for an additional 12 months upon receipt of a renewal application, proof of [initial or refresher, as appropriate,] training completion, and renewal fee in accordance with 18VAC15-60-130.

D. A [~~licensee's~~ renewal applicant's] submission of the renewal application and renewal fee to the board shall constitute a certification that the [~~licensee~~ renewal applicant] is in full compliance with the board's regulations.

18VAC15-60-150. Board discretion to deny renewal.

The board may deny renewal of a license for the same reasons as it may refuse initial licensure or discipline a regulant. The board may deny renewal of a license if the regulant has not met the terms of an agreement for licensure, has not satisfied all sanctions, or has not fully paid any monetary penalties or costs imposed by the board.

Part VI
Disciplinary Action and Reporting Requirements

18VAC15-60-160. Grounds for disciplinary action.

A. The board shall have the authority to fine any licensee; deny renewal of, suspend, or revoke any license issued by the board; deny application for any individual license or approval as a provider of a mold training course; and withdraw board approval of the provider of a mold training course provided for under Chapter 5 (§ 54.1-500 et seq.) of Title 54.1 of the Code of Virginia for:

1. Violating or inducing another person to violate any of the provisions of Chapters 1 (§ 54.1-100 et seq.), 2 (§ 54.1-200 et seq.), 3 (§ 54.1-300 et seq.), or 5 (§ 54.1-500 et seq.) of Title 54.1 of the Code of Virginia, or any of the provisions of this chapter.

2. Obtaining an individual license or approval as a mold training provider, or approval as a training manager or instructor through fraudulent means.

3. Altering, falsifying, or issuing a fraudulent Virginia individual mold license or a training certificate.

4. Violating any provision of any federal, state, or local law or regulation pertinent to mold remediation and mold inspection.

5. Having been found guilty by the board, another regulatory authority, or a court of any misrepresentation in the course of performing his mold inspection or remediation duties.

6. Subject to the provisions of § 54.1-204 of the Code of Virginia, having been convicted or found guilty, regardless of adjudication, in any jurisdiction of the United States of any felony or of any misdemeanor, there being no appeal pending therefrom or the time for appeal having elapsed. Any plea of nolo contendere shall be considered a conviction for the purposes of this chapter. A certified copy of the final order, decree, or case decision by a court or regulatory agency with lawful authority to issue such order, decree, or case decision shall be admissible as prima facie evidence of such conviction or discipline.

7. Failing to notify the board in writing within 30 days of pleading guilty or nolo contendere or being convicted or found guilty of any felony or of any misdemeanor.

8. Negligence or a continued pattern of incompetence in the practice of the discipline in which an individual mold license is held.

9. Failing or neglecting to send any information or documentation that was requested by the board or its representatives.

10. Failing to comply with 18VAC15-60-170.

11. [~~Acting as or being an ostensible licensee for undisclosed persons who do or will control or direct, directly or indirectly, the operations of the licensee's business~~ Failing to keep board-approved training and license current].

B. Any person whose license, approval as a mold training provider, or approval as a training manager or instructor is revoked or withdrawn under this section shall not be eligible to reapply for a period of one year from the effective date of the final order of revocation or withdrawal of approval. The person shall meet all education, experience, training, and documentation requirements, complete the application, and submit the required fee for consideration as a new applicant.

C. The board shall conduct disciplinary procedures in accordance with §§ 2.2-4019 and 2.2-4021 of the Administrative Process Act.

18VAC15-60-170. Maintenance of license.

A. A regulant shall report all changes of address to the board in writing within 30 calendar days of the change and shall return the license to the board. A physical address is required for each license. A post office box is acceptable only when a physical address is also provided. If the regulant holds more than one license issued by the board, the regulant shall inform the board of all licenses affected by the address change.

B. A regulant shall operate under the name in which the license is issued. Regulants shall report any change of individual name to the board in writing within 30 calendar days of the name change and shall return the license to the board. If the regulant holds more than one license issued by the board, the regulant shall inform the board of all licenses affected by the name change.

C. No license issued by the board shall be assigned or otherwise transferred.

18VAC15-60-180. Notice of adverse action.

Regulants shall notify the board of the following actions:

1. Any disciplinary action taken by another jurisdiction, board, or administrative body of competent jurisdiction including, but not limited to, any reprimand, revocation, suspension or denial, monetary penalty, or requirement for remedial education or other corrective action taken on any license, certification, registration, or authorization of the regulant.

2. Any voluntary surrendering of a license, certificate, registration, approval, or authorization done in connection with an open disciplinary action in another jurisdiction.

3. Any conviction or finding of guilt, regardless of adjudication or deferred adjudication, of any felony or of any misdemeanor. Any plea of nolo contendere shall be considered a conviction for the purpose of this section.

All notices must be made to the board in writing within 30 days of the action. A copy of the order or other supporting documentation must accompany the notice. The record of conviction, finding, or case decision shall be considered prima facie evidence of a conviction or finding of guilt.

18VAC15-60-190. Response to inquiry and provision of records.

A. A regulant must promptly respond to the board or any of its agents regarding a complaint.

B. The regulant must promptly produce to the board or any of its agents, any document, book, record, or copy thereof in which the regulant was involved or that is in the regulant's possession or control concerning a transaction covered by this chapter, or for which the regulant is required to maintain records.

C. A regulant shall not provide a false, misleading, or incomplete response to the board or any of its agents seeking information in the investigation of a complaint filed with the board.

Part VII
Training Provider and Training Course Requirements

18VAC15-60-200. Training provider personnel.

A. Training managers.

1. Approved mold training course providers shall designate a board-approved training manager to administer the mold training courses offered by the provider. The training manager shall meet the following requirements:

a. Have a minimum of two years experience in teaching adults; or

b. Have a minimum of three years experience in the mold remediation industry.

2. Training managers shall be responsible for ensuring that the training provider complies at all times with the requirements of this chapter. Training managers shall also be responsible for:

a. Maintaining the validity and integrity of each course examination to ensure that it accurately evaluates the student's knowledge and retention of the course topics.

b. Designating course instructor(s).

c. Developing and implementing a quality control plan. The plan shall be used to maintain and improve the quality of the approved mold training courses as advances in the industry are made. This plan shall contain at least the following elements:

(1) Procedures for periodic revision of training materials and course test to reflect innovations in the field.

(2) Procedures for the training manager's annual review of instructor competency.

3. Any training manager who intends to also serve as an instructor shall meet the requirements of subsection B of this section.

B. Training course instructors.

1. Mold training course instructors are responsible for the organization of the course and oversight of the teaching of all course material.

2. Board-approved mold training courses shall only utilize board-approved instructors to teach a mold training course. All instructors shall have a minimum of 24 hours of mold specific training and two years of experience in the mold remediation or mold assessment industry.

3. Guest instructors may be utilized to assist in teaching a mold training course and shall be exempt from the instructor qualifications in this subsection. Guest instructors are limited to no more than two hours of instruction per course per day.

C. Documentation of instructors and training manager.

1. The following documents shall be recognized by the board as proof that training managers and instructors meet the relevant work experience and training requirements specifically listed in this section:

a. Signed letters of reference or verification letters from the applicant's supervisor as proof of meeting the work experience requirements.

b. Certificates from mold-specific training courses as proof of meeting the training requirements.

2. Instructor qualifications shall be reviewed and approved by the board prior to the instructor teaching an approved mold training course.

3. Instructors will be notified in writing of their approval to teach mold training courses.

18VAC15-60-210. Training course general requirements.

A. In no case shall actual mold training exceed eight hours in a 24-hour period.

B. The total hours of actual training for any training course, including examination, shall be completed within a continuous two-week time frame, from start to finish.

C. All initial and refresher approved mold training courses shall be discipline specific.

D. Approved mold remediator supervisor and mold inspector training courses shall be taught in English.

E. Prior to the start of any approved mold training course, the training provider shall prepare a course outline that shall be distributed to each student at the start of the course. The outline shall contain the following minimum information:

1. Training course title and total hours of training;

2. Course instructor(s); and

3. Daily schedule specifying the time of each training topic, activity, break, and the examination.

F. Approved mold training course providers shall issue a course completion certificate to each individual who attends the course in full and successfully completes all course requirements. The certificate shall include the following information:

1. Training course title and length of training in hours. For mold remediator worker courses completed in languages other than English, the certificate shall indicate the language of the course.

2. Name, address, and telephone number of the training provider.

3. Complete address of training location.

4. Name and address of the student.

5. Unique certificate number generated by the training provider.

6. Statement affirming that the student attended the course and successfully completed its examination.

7. Examination date.

8. Training certificate expiration date. The training certificate expiration date for any mold remediator supervisor or mold inspector course shall be 12 months from the last day of the month when the course was completed. For any mold remediator worker course, the certificate expiration date shall be [~~24~~ 36] months from the last day of the month when the course was completed.

9. Signature and name of the approved mold training course provider's training manager and course instructor. The signatures may be printed facsimiles.

18VAC15-60-220. Worker course requirements.

A. The mold remediator worker initial course shall include lectures, demonstrations, and other activities directly related to the duties of a mold remediator worker.

B. The mold remediator worker initial course shall last a minimum of 16 hours with a minimum of six hours of hands-on training and shall address the following topics:

1. Role and responsibilities of a mold [~~remediation~~ remediator] worker.

2. Background information on mold including health effects.

3. Relevant federal, state, and local regulatory requirements related to mold remediation activities including the requirements of this chapter.

4. Employee personal protective equipment.

5. Workplace safety hazards, including other environmental hazards such as lead and asbestos.

6. Knowledge of building construction as related to eliminating moisture problems including elements of airflow, mechanisms of moisture and heat flow, humidity, the building envelope, and porous and nonporous materials.

7. Current relevant industry work practices [and standards].

8. Course review of key concepts.

9. Examination.

C. The mold remediator worker refresher course shall last a minimum of four hours and include the following topics:

1. Comprehensive review of the initial course topics with specific emphasis and update on current [relevant] mold remediation industry [work practices and] standards.

2. Examination.

18VAC15-60-230. Supervisor course requirements.

A. The mold remediator supervisor initial course shall include lectures, demonstrations, and other activities directly related to the duties of a mold remediator supervisor.

B. The mold remediator supervisor initial course shall last a minimum of 24 hours with a minimum of eight hours of hands-on training and shall address the following topics:

1. Role and responsibilities of a mold [~~remediation~~ remediator] supervisor.

2. Background information on mold including health effects.

3. Relevant federal, state, and local regulatory requirements related to mold remediation activities, including the requirements of this chapter.

4. Employee personal protective equipment.

5. Workplace safety hazards, including other environmental hazards such as lead and asbestos.

6. Knowledge of building construction as related to eliminating moisture problems, including elements of airflow, mechanisms of moisture and heat flow, humidity, the building envelope, and porous and nonporous materials.

7. Current relevant industry work practices [and standards], including the use and reading of moisture meters, duct cleaning, and use of drying equipment.

8. Development and implementation of an occupant protection plan and a remediation activities report.

9. Liability and insurance issues relating to mold remediation.

10. Overview of sampling and mold inspection report interpretation.

11. Contract specification key elements.

12. Recordkeeping for mold remediation projects.

13. Supervisory techniques for mold remediation activities including implementation of required work practices and prevention of unsafe work practices.

14. Course review of key concepts.

15. Examination.

C. The mold remediator supervisor refresher course shall last a minimum of four hours and include the following topics:

1. Comprehensive review of the initial course topics with specific emphasis and update on current [relevant] mold remediation industry [work practices and] standards.

2. Review of contract specifications, mold inspection reports, and other pertinent records.

3. Examination.

18VAC15-60-240. Inspector course requirements.

A. The inspector initial course shall include lectures, demonstrations, and other activities directly related to the duties of a mold inspector.

B. The mold inspector initial course shall last a minimum of 24 hours with a minimum of four hours of hands-on training and shall address the following topics:

1. Role and responsibilities of a mold inspector.

2. Background information on mold including health effects.

3. Relevant federal, state, and local regulatory requirements related to mold remediation activities, including the requirements of this chapter.

4. Employee personal protective equipment.

5. Workplace safety hazards, including other environmental hazards such as lead and asbestos.

6. Knowledge of building construction as related to eliminating moisture problems, including elements of airflow, mechanisms of moisture and heat flow, humidity, the building envelope, and porous and nonporous materials.

7. Current relevant industry work practices [and standards], including the use and reading of moisture meters and an understanding of HVAC systems.

8. Pre-inspection planning and review of previous inspection records.

9. Mold inspection report interpretation and recordkeeping.

10. Liability and insurance issues relating to mold inspection.

11. Inspection and sampling techniques for mold and assessment of the condition of mold.

12. Designing a mold [~~remediation~~ management] plan [and mold remediation protocol] to be carried out by a mold [~~remediation~~ remediator] supervisor and workers.

13. Public/employee/building occupant relations.

14. Course review of key concepts.

15. Examination.

C. The mold inspector refresher course shall last a minimum of four hours and include the following topics:

1. Comprehensive review of the initial course topics with specific emphasis and update on current [relevant] mold inspection and remediation industry [work practices and] standards.

2. Review of mold inspection reports, remediation plans, and other pertinent records related to mold inspection.

3. Examination.

18VAC15-60-250. Examinations.

A. Upon the conclusion of instruction and training course activities, the training provider shall administer an examination to the students. The purpose of the examination is to measure the overall effectiveness of the training by testing the student's knowledge and retention of the topics covered during the course.

B. Course examinations shall be administered by the course instructor or training manager and must cover the topics included in the training course.

C. All examinations shall be closed-book, multiple choice questions, with a passing score of 70% or higher. The requirements for the examination of each course shall be as follows:

1. The mold remediator worker initial examination shall consist of 50 items.

2. The mold remediator supervisor initial examination shall consist of 100 items.

3. The mold inspector initial examination shall consist of 100 items.

4. All refresher course examinations shall consist of 50 items.

D. The examination for all mold remediator supervisor and mold inspector courses shall be read and answered in writing by the student. The examination for any mold remediator worker course may be given to the student orally only if the student is unable to read and answer the examination in writing.

E. Students shall be allowed two attempts to pass the examination immediately following the conclusion of course instruction and activities. If the student is unable to pass the examination after two attempts, the course shall be repeated in its entirety before the student shall be allowed to take the examination again.

Part VIII
Standards of Practice and Conduct for Approved Mold Training Programs

18VAC15-60-260. Recordkeeping.

A. Each approved mold training provider shall maintain and make available upon request from the board the following records:

1. All documents specified in 18VAC15-60-200 that demonstrate the qualifications of the training manager and instructors.

2. Copies of each current course outline and training certificate as specified in 18VAC15-60-210.

3. Copies of each course examination and applicable answer keys.

4. Results of each student's course examination and a copy of each student's course completion certificate.

5. Copies of any of the material that was submitted to the board as a part of the training provider's original application for board approval.

6. Any other material not listed in this chapter that is utilized by the training provider in any of the training courses for which it is approved.

B. Training providers shall maintain the above records for a minimum period of three years.

18VAC15-60-270. Changes to approved training providers.

A. When an approved mold training provider offering any approved mold training course has a change of ownership, the new owner shall make written notification to the board within 30 days of the change of ownership. The new owner [~~must~~ shall] comply with the requirements of this chapter in order to maintain approval.

B. After a mold training course has been approved, any substantial changes in the training course shall be submitted to the board for review and approval prior to the continuation of the approved mold training course, which includes the following:

1. Course curriculum.

2. Course examination.

3. Course training materials.

4. Training manager and instructors.

5. Certificate of completion.

C. The board shall communicate its approval or disapproval of any changes in the same manner as for initial applications for course approval.

D. The approved mold training provider shall notify the board no less than 30 days prior to relocating its business, transferring its records, changing its telephone number, changing its course instructors, or ceasing its business operations.

18VAC15-60-280. Status of approval.

The board may withdraw approval of any mold training course for the following reasons:

1. The training program manager, instructors, or training courses no longer meets the standards established in this chapter.

2. The board determines that the provider is not conducting the training in a manner that meets the requirements as set forth in this chapter.

3. The training provider fails to comply with a board request for documentation or other materials from the provider.

Part IX
Standards for Conducting Mold Inspection and Remediation Activities

18VAC15-60-290. General standards of individual practice and conduct.

A. Individuals conducting mold inspection or mold remediation activities shall comply with the work practice standards enumerated in this chapter.

B. Individuals conducting mold inspections or mold remediations shall comply with § 54.1-1100 et seq. of the Code of Virginia as appropriate.

C. Inspectors and remediators shall comply with all other relevant local, state, and federal regulations including 29 CFR Part 1910, 29 CFR Part 1926, and other regulations as applicable to mold inspection and remediation.

D. Upon encountering any regulated hazardous materials for which the remediator or inspector is not qualified to handle including, but not limited to, asbestos and lead, [~~he~~ the remediator or inspector] shall inform the [~~homeowner,~~] building owner [~~,~~] or his agent, as appropriate, and advise of the need for services [~~of any requisite~~ from the appropriate] qualified professionals.

18VAC15-60-300. Mold [~~remediation workers~~ remediator worker].

A licensed mold remediator worker shall conduct mold remediation activities as directed by the mold [~~remediation~~ remediator] supervisor.

18VAC15-60-310. Mold remediator supervisor.

A. [The building owner or his agent shall be advised in writing by the mold remediator supervisor that a third party pre-remediation inspection prior to the start of the mold remediation project and a third-party post-remediation inspection at the conclusion of the mold remediation project are options.]

[~~A.~~ B.] A licensed mold remediator supervisor shall be physically present at all times that mold remediation activities are being conducted.

[~~B.~~ C.] The licensed mold [~~remediation~~ remediator] supervisor shall ensure that all remediation activities are conducted according to the requirements of this chapter and all other applicable federal, state, and local laws and regulations.

[~~C.~~ D.] The licensed mold remediator supervisor shall be responsible for following the [~~remediation scope of work~~ mold management plan and mold remediation protocol].

[~~D.~~ E.] The licensed mold remediator supervisor shall keep a daily log of mold remediation activities, which shall include the following minimum information:

1. The name and license number of each mold remediator worker that participated in whole or in part of the remediation.

2. The start and end dates of the remediation.

3. Records of any readings taken by the workers or supervisor as part of the remediation.

[~~E.~~ F.] Upon completion of the remediation, the licensed mold remediator supervisor shall sign a statement declaring that the remediation scope of work has been completed. The statement shall be retained as part of the record for the mold remediation.

18VAC15-60-320. Mold inspector.

[~~The duties and functions of a mold inspector shall include, but not be limited to, determining the presence and location of mold, determining the condition of mold, sampling of mold, designing a site-specific mold remediation plan, or making recommendations for additional work by qualified professionals to address issues beyond the scope of the mold inspector.~~] Licensed mold inspectors shall conduct inspection activities in accordance with the following:

1. The [visual inspection and physical] sampling of mold shall be conducted using documented methodologies that incorporate adequate quality control procedures;

2. [Air sampling for the presence of mold is optional, but when performed shall be conducted using documented methodologies that incorporate adequate quality control procedures;]

[~~2.~~ 3.] Collected mold samples shall be sent to a laboratory capable of performing mold analysis that is accredited or certified by an organization that meets international program requirements established under ISO/IEC 17011;

[~~3.~~ 4.] The licensed inspector shall prepare an inspection report after his completion of the mold inspection. The report shall include the following minimum information:

a. Dates of the start and finish of each inspection;

b. Physical address of the building receiving the inspection;

c. Name and address of the building owner;

d. Name, signature, and license number of each licensed inspector conducting testing;

e. Name, address, and telephone number of the firm employing each inspector;

f. Each device and sampling procedure employed for mold inspection, including instrument calibration data;

g. Specific locations of each mold sample taken;

h. Location [, condition,] and type of all mold identified during inspection;

i. Copy of the laboratory report containing the results of all mold sampled from the inspection;

j. Explanation of the potential source and cause of the mold or recommendations for further investigation of the mold intrusion by qualified professionals; and

k. Mold [~~remediation~~ management] plan [and mold remediation protocol] , if contracted to perform [~~this~~

~~duty~~ these duties] by the building owner or his authorized agent [, using documented methodologies that incorporate adequate quality control procedures];

[~~4.~~ 5.] All inspection reports [, ~~and remediation~~ mold management] plans [, and mold remediation protocols] shall be maintained by the licensed inspector who prepared them for at least three years after the date of the completion of the inspection. The licensed inspector shall provide copies of the reports and plans to the building owner or to the person that contracted for his services; and

[~~5.~~ 6.] If contracted to perform a post-remediation verification by the building owner or his authorized agent, the licensed mold inspector shall use documented methodologies that incorporate adequate quality control procedures.

a. Following a remediation, a visual inspection shall be performed by the licensed inspector to determine if there is any evidence of the presence of mold.

b. If mold is still present contrary to the specifications of the remediation plan, these conditions shall be remediated prior to the continuation of the post-remediation inspection.

Part X
General Standards of Practice and Conduct

18VAC15-60-330. Responsibility to the public.

The primary obligation of the licensee shall be to the public. If the licensee's judgment is overruled under circumstances when the safety, health, property, or welfare of the public is endangered, the licensee shall inform the employer or client of the possible consequences and notify the appropriate authorities if the situation is not resolved. The licensee shall take such action only when his authority to correct a problem has been ignored or overruled.

18VAC15-60-340. Public statements.

A. The licensee shall be truthful in all matters relating to the performance of mold remediation and mold inspection services.

B. When serving as an expert or technical witness, the licensee shall express an opinion only when it is based on an adequate knowledge of the facts in issue and on a background of technical competence in the subject matter. Except when appearing as an expert witness in court or an administrative proceeding when the parties are represented by counsel, the licensee shall issue no statements, reports, criticisms, or arguments on matters relating to practices that are inspired or paid for by an interested party or parties unless the licensee has prefaced the comment by disclosing the identities of the party or parties on whose behalf the licensee is speaking, and by revealing any self-interest.

C. Licensees or applicants for license shall not knowingly make a materially false statement, submit falsified documents, or fail to disclose a material fact requested in connection with an application for licensure or licensure renewal submitted to the board by any individual.

18VAC15-60-350. Solicitation of work.

In the course of soliciting work:

1. The licensee shall not bribe;

2. The licensee shall not falsify or permit misrepresentation of the licensee's work or an associate's academic or professional qualifications, nor shall the licensee misrepresent the degree of responsibility for prior assignments;

3. Materials used in the solicitation of employment shall not misrepresent facts concerning employers, employees, associates, joint ventures, or past accomplishments of any kind; and

4. Materials used in the solicitation of services shall not misrepresent facts of approval or any federal, state, or local requirements.

18VAC15-60-360. Professional responsibility.

A. The licensee or approved mold training provider shall, upon request or demand, produce to the board, or any of its representatives, any plan, document, book, record, or report in his possession concerning a transaction covered by this chapter, and shall cooperate in the investigation of a complaint filed with the board against a licensee or approved mold training provider.

B. A licensee or approved mold training provider shall not use the design, plans, or work of another licensee or approved mold training provider without the original professional's knowledge and consent and, after consent, a thorough review to the extent that full responsibility shall be assumed by the user.

C. The mold inspector shall not disclose any information concerning the results of the mold inspection without the approval of the client for whom the mold inspection was performed. However, the mold inspector may disclose information in situations where imminent danger exists to life or health.

D. Approved mold training providers shall admit board representatives for the purpose of conducting an on-site audit or any other purpose necessary to evaluate compliance with this chapter to maintain board approval and other applicable laws and regulations.

18VAC15-60-370. Good standing in other jurisdictions.

A. Licensees that perform mold remediation work or inspections in other jurisdictions and approved mold training providers, training managers, or instructors that offer mold

training in other jurisdictions shall be in good standing in every jurisdiction where licensed, certified, or approved by an authorizing agency and shall not have had a license, certification, or approval suspended, revoked, or surrendered in connection with any disciplinary action.

B. Licensees and approved mold training providers, training managers, and instructors shall notify the board in writing no later than 10 days after the final disciplinary action taken by another jurisdiction against their license or approval to perform mold remediation or inspection activities or offer mold training.

C. Licensees may be subject to disciplinary action for disciplinary actions taken by another jurisdiction. Approved mold training providers, training managers, and instructors may be subject to withdrawal of board approval to offer mold training as a result of disciplinary actions taken by another jurisdiction.

18VAC15-60-380. Conflict of interest.

A. No licensed [~~mold remediator worker or~~] mold remediator supervisor shall perform a mold remediation project if the mold remediation is to be performed by any individual with an employer/employee relationship [~~with~~], or financial interest in, the licensed mold inspector who conducted the inspection of the property [unless the licensed mold remediator supervisor discloses the employer/employee relationship or financial interest to the building owner or his agent. A department-generated disclosure form shall be signed and dated by the licensed mold remediator supervisor and the building owner or his agent prior to the signing of any proposal or contract].

B. No licensed mold inspector shall perform a mold inspection if the inspection is to be performed by any individual with an employer/employee relationship [~~with~~], or financial interest in, the [~~licensed mold remediation worker or~~] licensed mold [~~remediation~~ remediator] supervisor who conducted a remediation of the property [unless the license mold inspector discloses the employer/employee relationship or financial interest to the building owner or his agent. A department-generated disclosure form shall be signed and dated by the licensed mold inspector and the building owner or his agent prior to the signing of any proposal or contract].

C. [~~No licensed mold remediator worker or supervisor or licensed mold inspector~~ The licensee] shall [not] accept compensation, financial or otherwise, from more than one interested party for the same service on the same property without the written consent of all interested parties.

D. The licensee shall not accept commissions or allowances [~~from nor offer to, directly or indirectly, other parties dealing with the client~~ nor offer commissions or allowances,] in connection with work for which the licensee is responsible [either directly or indirectly from other parties]. Additionally, the licensee shall not enter into any financial relationship with any party that may compromise the licensee's commitment to the best interest of his client.

E. The mold inspection shall not be used as a tool by the licensee to solicit or obtain work in another field, except for additional diagnostic inspections or testing.

18VAC15-60-390. Responsibilities of a licensee.

A. A licensee or approved mold training provider shall respond to an inquiry from the board or any of its agents within 15 business days.

B. A licensee shall produce to the board or any of its agents, upon demand, any written reports and supporting documentation concerning any mold remediation or mold inspection in which the licensee was involved, as well as any other records that the licensee shall maintain as required by this chapter.

C. A licensee shall keep the board informed of his current home address at all times. Changes of address shall be reported to the board in writing within 30 calendar days after such change. A physical address is required; a post office box is only acceptable when provided in addition to the licensee's physical address. The board shall not be responsible for the licensee's failure to receive the board's correspondence as a result of the licensee's failure to inform the board of his correct address.

D. A licensee shall notify the board in writing of a name change within 30 calendar days after any change in the licensee's legal name. Such notification shall be accompanied by a copy of a marriage certificate, divorce decree, court order, or other documentation that verifies the name change and was issued by an organization with the authority to make such a change.

E. A licensee shall retain all records pertaining to mold remediations and mold inspections performed including, but not limited to, all written reports and supporting documentation for a period of three years from the date of the completion of the mold remediation or mold inspection.

[F. Each licensee shall keep his board-approved training and license current.]

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

[FORMS (18VAC15-60)

Mold License Application, A506-33MLIC (eff. 7/11)

Mold Education Verification Form, A506-33MED (eff. 7/11)

Mold Experience Verification Form, A506-33MEXP (eff. 7/11)

Mold Inspectors/Remediators Membership Form, A506-33MAMF (eff. 7/11)

Mold Remediator Supervisor/Inspector Disclosure Form, A506-33MDIS (eff. 7/11)

Mold Training Provider/Course Application, A506-33MTCAPP (eff. 7/11)]

DOCUMENTS INCORPORATED BY REFERENCE (18VAC15-60)

ASTM E1527-05, Standard Practice for Environmental Site Assessments: Phase I Environmental Site Assessment Process, ASTM International.

ISO/IEC 17011:2004(E), Conformity Assessment - General Requirements for Accreditation Bodies Accrediting Conformity Assessment Bodies, International Organization for Standardization.

VA.R. Doc. No. R10-2048; Filed May 4, 2011, 9:38 a.m.

TITLE 22. SOCIAL SERVICES

STATE BOARD OF SOCIAL SERVICES

Final Regulation

REGISTRAR'S NOTICE: The State Board of Social Services has claimed an exemption from the Administrative Process Act in accordance with § 2.2-4006 A 4 a of the Code of Virginia, which excludes regulations that are necessary to conform to changes in Virginia statutory law or the appropriation act where no agency discretion is involved. The State Board of Social Services will receive, consider, and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: **22VAC40-41. Neighborhood Assistance Tax Credit Program (amending 22VAC40-41-10).**

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

Effective Date: July 1, 2011.

Agency Contact: J. Mark Grigsby, Director, Office of Community Service, Department of Social Services, 801 East Main Street, Richmond, VA 23219, telephone (804) 726-7922, FAX (804) 726-7946, TTY (800) 828-1120, or email james.grigsby@dss.virginia.gov.

Summary:

The amendments reflect changes enacted by Chapters 312 and 370 of the 2011 Acts of Assembly, relating to the Neighborhood Assistance Act. Specifically, the term "business firm" is amended to permit trusts to be eligible for the Neighborhood Assistance Act income tax, and the term "impoverished people" is defined as individuals with family annual incomes not in excess of 200% of the current poverty guidelines.

22VAC40-41-10. Definitions.

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

"Approved organization" means a neighborhood organization that has been found eligible to participate in the Neighborhood Assistance Program.

"Audit" means any audit required under the federal Office of Management and Budget's Circular A-133, or, if a neighborhood organization is not required to file an audit under Circular A-133, a detailed financial statement prepared by an outside independent certified public accountant.

"Business firm" means any corporation, partnership, electing small business (Subchapter S) corporation, limited liability company, or sole proprietorship authorized to do business in this Commonwealth subject to tax imposed by Articles 2 (§ 58.1-320 et seq.) and 10 (§ 58.1-400 et seq.) of Chapter 3, Chapter 12 (§ 58.1-1200 et seq.), Article 1 (§ 58.1-2500 et seq.) of Chapter 25, or Article 2 (§ 58.1-2620 et seq.) of Chapter 26 of Title 58.1 of the Code of Virginia. "Business firm" also means any trust or fiduciary for a trust subject to tax imposed by Article 6 (§ 58.1-360 et seq.) of Chapter 3 of Title 58.1 of the Code of Virginia.

"Commissioner" means the Commissioner of the Department of Social Services, his designee or authorized representative.

"Community services" means any type of counseling and advice, emergency assistance, medical care, provision of basic necessities, or services designed to minimize the effects of poverty, furnished primarily to impoverished people.

"Contracting services" means the provision, by a business firm licensed by the Commonwealth of Virginia as a contractor under Chapter 11 (§ 54.1-1100 et seq.) of Title 54.1 of the Code of Virginia, of labor or technical advice to aid in the development, construction, renovation, or repair of (i) homes of impoverished people or (ii) buildings used by neighborhood organizations.

"Education" means any type of scholastic instruction or scholastic assistance to an individual who is impoverished.

"Housing assistance" means furnishing financial assistance, labor, material, or technical advice to aid the physical improvement of the homes of impoverished people.

"Impoverished people" means, for neighborhood organizations not providing education services, people in Virginia with incomes at or below ~~150%~~ 200% of the poverty guidelines updated periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 USC § 9902(2).

"Job training" means any type of instruction to an individual who is impoverished that enables him to acquire vocational skills so that he can become employable or able to seek a higher grade of employment.

"Neighborhood assistance" means providing community services, education, housing assistance, or job training.

"Neighborhood organization" means any local, regional or statewide organization whose primary function is providing neighborhood assistance for impoverished people, and holding a ruling from the Internal Revenue Service of the United States Department of the Treasury that the organization is exempt from income taxation under the provisions of § 501(c)(3) or § 501(c)(4) of the Internal Revenue Code of 1986, as amended from time to time, or any organization defined as a community action agency in the Economic Opportunity Act of 1964 (42 USC § 2701 et seq.), or any housing authority as defined in § 36-3 of the Code of Virginia.

"Professional services" means any type of personal service to the public which requires as a condition precedent to the rendering of such service the obtaining of a license or other legal authorization and shall include, but not be limited to, the personal services rendered by medical doctors, dentists, architects, professional engineers, certified public accountants, attorneys-at-law, and veterinarians.

"Scholastic assistance" means (i) counseling or supportive services to elementary school, middle school, secondary school, or postsecondary school students or their parents in developing a postsecondary academic or vocational education plan, including college financial options for such students or their parents, or (ii) scholarships.

VA.R. Doc. No. R11-2777; Filed April 25, 2011, 11:15 a.m.

STATE CORPORATION COMMISSION

Bureau of Insurance

April 21, 2011

Administrative Letter 2011-02

To: All Insurers Licensed to Write Property and Casualty Insurance in Virginia and All Interested Parties

Re: Certificates of Insurance

NOTE: EACH INSURER RECEIVING THIS ADMINISTRATIVE LETTER IS INSTRUCTED TO PROVIDE A COPY TO EACH OF ITS CURRENTLY APPOINTED AGENTS AND TO EACH NEWLY APPOINTED AGENT.

It has come to the attention of the Bureau of Insurance that widespread misunderstanding regarding the proper use of certificates of insurance, as well as the intentional misuse of such certificates, persists. For example, the Bureau has become aware that some private and public entities are requesting insurers and producers to issue certificates of insurance that are inconsistent with the underlying insurance policy or contract. For purposes of this administrative letter, the term "certificate" or "certificate of insurance" (regardless of how it is titled or described) means any document prepared or issued by an insurer or insurance producer as evidence of property and casualty insurance coverage.

A certificate of insurance is a summary of the referenced insurance policy and does not modify or amend the referenced policy or confer any right upon the certificate holder. The Bureau cautions insurers, producers, and all persons requesting certificates that certificates of insurance cannot be used to amend, expand, or alter the terms of the underlying insurance policy. Certificates should reflect clearly and accurately the coverage provided by the underlying policy as well as the terms and conditions of such policy. For example, it is improper for a producer to indicate in a certificate of insurance that a person is an additional insured contrary to the terms of the policy. Likewise, it is improper to state on a certificate of insurance that a party will be notified if the underlying policy is cancelled if that party is not entitled to notice under the terms of the policy.

Certificates of insurance that misrepresent any material term, condition, coverage, or other provision set forth in the underlying policy, or purport to amend or alter the underlying insurance policy violate the Virginia Insurance Code and subject producers and insurers to possible disciplinary action. It is imperative that producers and insurers issue certificates of insurance that accurately represent the terms and conditions of the policies as contracted between the insurer and the policyholder.

Questions relating to this administrative letter should be directed to George Lyle, P&C Consumer Services Section, Bureau of Insurance, P.O. Box 1157, Richmond, VA 23218, telephone (804) 371-9185, FAX (804) 371-9349.

/s/ Jacqueline K. Cunningham
Commissioner of Insurance

DEPARTMENT OF ENVIRONMENTAL QUALITY

Notice of Proposed Consent Order for the City of Fredericksburg

An enforcement action has been proposed for the City of Fredericksburg for alleged violations in the City of Fredericksburg at the Fredericksburg Waste Water Treatment Plant. The consent order describes a settlement to resolve permit effluent violations at the Fredericksburg Waste Water Treatment Plant. A description of the proposed action is available at the Department of Environmental Quality office named below or online at www.deq.virginia.gov. Daniel Burstein will accept comments by email at daniel.burstein@deq.virginia.gov, FAX at (703) 583-3821, or postal mail at Department of Environmental Quality, Northern Regional Office, 13901 Crown Court, Woodbridge, VA 22193, from May 24, 2011, through June 23, 2011.

Announcement of an Effort to Restore Water Quality in the Clinch River

Announcement of an effort to restore water quality in the Clinch River from Big Cedar Creek confluence downstream to the Dumps Creek confluence and the following tributaries: Maiden Spring Creek and Little River in Tazewell County, Virginia, and Indian Creek, Weaver Creek, Swords Creek, Lewis Creek, and Big Cedar Creek in Russell County, Virginia.

Public meeting location: Lebanon Town Hall, 405 West Main Street, Lebanon, Virginia, on May 26, 2011, from 6 p.m. to 8 p.m.

Purpose of notice: The Virginia Department of Environmental Quality (DEQ) and the Department of Conservation and Recreation are announcing an effort to restore water quality, a public comment opportunity, and public meeting.

Meeting description: First public meeting on a study to restore water quality.

Description of study: DEQ has been working to identify sources of bacterial contamination in the Clinch River and tributaries including Maiden Spring Creek and Little River in Tazewell County, Virginia, and Indian Creek, Weaver Creek, Swords Creek, Lewis Creek, and Big Cedar Creek in Russell County, Virginia. The streams are impaired for failure to meet the recreational use because of fecal coliform bacteria violations and violation of the E. coli standard.

During the study, DEQ will determine the sources of bacterial contamination and develop a total maximum daily load (TMDL) for bacteria. To restore water quality, contamination levels must be reduced to the TMDL amount. A TMDL is the total amount of a pollutant a water body can contain and still meet water quality standards.

How a decision is made: The development of a TMDL includes public meetings and a public comment period once the study report is drafted. After public comments have been considered and addressed, DEQ will submit the TMDL report to the U.S. Environmental Protection Agency for approval.

How to comment: DEQ accepts written comments by email, fax, or postal mail. Written comments should include the name, address, and telephone number of the person commenting and be received by DEQ during the comment period, May 26, 2011, to June 27, 2011. DEQ also accepts written and oral comments at the public meeting announced in this notice.

To review fact sheets: Fact sheets are available on the impaired waters from the contacts below or on the DEQ website at www.deq.virginia.gov/tmdl.

Contact for additional information: Martha W. Chapman, TMDL Coordinator, Virginia Department of Environmental Quality, Southwest Regional Office, 355 Deadmore Street, P.O. Box 1688, Abingdon, VA 24212-1688, telephone (276) 676-4800, FAX (276) 676-4899, or email martha.chapman@deq.virginia.gov.

Announcement of Public Meeting for Draft Implementation Plan for the James River and Tributary Bacteria Impairments in Richmond City and Chesterfield, Henrico, Goochland, and Powhatan Counties

Public meeting: A public meeting will be held Wednesday, May 18, 2011, at 6 p.m. at the Central Office location of the Department of Environmental Quality (DEQ) located at 629 East Main Street in Richmond, VA 23218.

Purpose of notice: The Virginia Department of Environmental Quality will host a public meeting to provide a summary of the draft implementation plan (IP), which incorporates results of the recently completed total maximum daily load (TMDL) study. A public comment period beginning on May 19, 2011, and ending on June 20, 2011, will allow stakeholder input of the draft document. The draft will be made available online by the day of or the day after the public meeting at: http://www.deq.virginia.gov/tmdl/ipproj.html.

Meeting description: The goal of the IP process is to outline a plan for reaching the pollutant reduction goals of a completed TMDL study. The plan will identify the type and number of "best management practices" (BMPs) that may be implemented in order to mitigate the bacteria pollution in the waterways. The plan also identifies funding opportunities and estimates the costs of remedial efforts. DEQ has been working with area stakeholders as part of the implementation planning process for the James River (Richmond) area bacteria impairments since the project was initiated in November 2010. DEQ has met with watershed working-groups and a steering committee was formed to incorporate and evaluate information from local governments, non-profit groups, and citizens for the plan.

Description of TMDL: Virginia agencies developed a TMDL report to identify sources of the bacterial contamination in the waters of the James River and it's tributaries in the following jurisdictions:

Stream	County/City	Length (mi.)	Impairment
Bernards Creek	Chesterfield, Powhatan	6.97	Bacteria (Primary Contact Use)
Powhite Creek	Chesterfield, Richmond City	8.12	
Reedy Creek	Richmond City	3.68	
James River (riverine - lower)	Richmond City	2.99	
Gillie Creek	Richmond City, Henrico	5.79	
Almond Creek	Henrico	2.26	
Goode Creek	Richmond City	1.23	
Falling Creek	Chesterfield	3.81	
No Name Creek	Chesterfield	1.83	
James River (tidal)	Chesterfield, Henrico, Richmond City	10.84 (sq. miles)	
Tuckahoe Creek	Goochland, Henrico	8.7	

These streams are impaired for failure to meet the primary contact (recreational) designated use because of bacteria standard violations. The study reported on sources of bacterial contamination and recommended TMDLs for the impaired waters. A TMDL is the total amount of a pollutant a water body can contain and still meet water quality standards. To restore water quality, bacterial levels must be reduced to the TMDL amount. The James River and tributaries report, which was submitted to EPA on September 30, 2010, is available on the DEQ website at http://www.deq.virginia.gov/tmdl/apptmdls/jamesrvr/jamesg3.pdf. The Tuckahoe Creek watershed TMDL study was developed by DEQ and approved by EPA on September 20, 2004, and is available on the DEQ website at http://www.deq.virginia.gov/tmdl/apptmdls/jamesrvr/tuckcr.pdf.

Implementation plan development: Implementation plan development is required by Virginia state law under the Water Quality Monitoring, Information, and Reporting Act (WQMIRA). The development of an implementation plan includes a minimum of two public meetings and two public comment periods prior to submitting the final draft IP to the State Water Control Board for approval. In addition to the required public meetings, DEQ and contractor MapTech also hosted a brainstorming session and two formal workgroup meetings as well as three steering committee meetings. Meeting minutes are available at http://www.deq.virginia.gov/tmdl/ipproj.html for review.

How to comment: DEQ accepts written comments by email, fax, or postal mail. Written comments should include the name, address, and telephone number of the person commenting and be received by DEQ during the comment period, which will begin on May 19, 2011, and end on June 20, 2011.

Contact for additional information: Margaret Smigo, TMDL Coordinator, Virginia Department of Environmental Quality, Piedmont Regional Office, 4949A Cox Road, Glen Allen, VA 23060, telephone (804) 527-5124, FAX (804) 527-5106, or email margaret.smigo@deq.virginia.gov.

Notice of Public Meeting and an Opportunity for Public Comment Regarding No Discharge Zone

Public meeting: Tuesday, May 31, 2011, 6 p.m., in the Northumberland County Courts Building (new courthouse), 39 Judicial Place, Heathsville, VA 22473.

Purpose of notice: The Virginia Department of Environmental Quality (DEQ) is announcing its intent to apply to the U.S. Environmental Protection Agency (EPA) for a federal No Discharge Zone and is seeking public comment on the draft application.

Meeting description: This public meeting is to provide a summary of a draft application for designation of selected waterbodies within Northumberland County (Jarvis, Prentice, Dividing, and Cloverdale Creeks, Great and Little Wicomico Rivers, Big Fleets Pond, Little Taskmakers and Taskmakers Creeks, Owens, Gaskins, and Flag Ponds, Hack, Cubitt, Hull, Cod, and Presley Creeks, Corbin Pond, Coan River and the Glebe, Judith Sound, and the Yeocomico River) and a portion of one waterbody in Westmoreland County (Yeocomico River) as federal No Discharge Zones (NDZs). The NDZ designation would prohibit the overboard discharge of treated sewage effluent from marine sanitation devices (MSDs) in these waterways.

Description of study: House Bill 1774 (Chapter 337 of the 2009 Acts of Assembly) resolves that all tidal creeks in Virginia be designated federal No Discharge Zones, and directs DEQ to pursue this designation. It is currently illegal to discharge raw sewage in U.S. territorial waters. In a NDZ, this ban is expanded to include sewage treated by on-board marine sanitation devices. A NDZ is determined by EPA upon application from the states, and is contingent on the states' demonstrating: (i) the need for enhanced protection of water quality, (ii) the availability of sufficient local alternatives to overboard discharge (i.e. pump-outs), and (iii) local stakeholder support. DEQ is seeking this designation as one component of a clean-up plan for small tidal Chesapeake Bay tributaries, which are frequently impaired for shellfish harvest due to elevated levels of fecal bacteria. DEQ has conducted an analysis of boat traffic and pump-out availability for the waterbodies proposed for NDZs in Northumberland County (and a portion of one waterbody in Westmoreland County), and concluded that existing pump-out facilities are adequate to service estimated peak demand. A draft application to EPA for No Discharge Zone designation has been prepared and will be available for public review and comment on the DEQ website at http://www.deq.virginia.gov/tmdl/ndz.html the day of or the day after the public meeting. Presentations provided at the meeting will also be made available on the website.

How to comment: DEQ will accept written comments beginning June 1, 2011, by email, fax, or postal mail. Comments should include the name, address, and telephone number of the person commenting and be received by DEQ during the comment period, which will expire on Thursday, June 30, 2011.

Contact for additional information: Margaret Smigo, TMDL Coordinator, Virginia Department of Environmental Quality, Piedmont Regional Office, 4949A Cox Road, Glen Allen, VA 23060, telephone (804) 527-5124, FAX (804) 527-5106, or email margaret.smigo@deq.virginia.gov.

STATE LOTTERY DEPARTMENT

Director's Orders

The following Director's Orders of the State Lottery Department were filed with the Virginia Registrar of Regulations on April 27, 2011, and on May 4, 2011. The orders may be viewed at the State Lottery Department, 900 East Main Street, Richmond, VA, or at the office of the Registrar of Regulations, 910 Capitol Street, 2nd Floor, Richmond, VA.

Director's Order Number Twenty-Seven (11)

Virginia Lottery's "Nascar® Summer Fun Sweepstakes" Final Rules for Game Operation (effective April 27, 2011)

Director's Order Number Thirty-Seven (11)

"Kroger Fuel Retailer Incentive Promotion" Virginia Lottery Retailer Incentive Program Rules (effective May 3, 2011, nunc pro tunc to April 25, 2011)

Director's Order Number Thirty-Nine (11)

Virginia's Instant Game Lottery 1266; "Spicy 7's" Final Rules for Game Operation (effective May 3, 2011)

Director's Order Number Forty (11)

Virginia's Instant Game Lottery 1251; "Money Money Money" Final Rules for Game Operation (effective May 3, 2011)

Director's Order Number Forty-One (11)

Virginia's Instant Game Lottery 1254; "Slots of Fun!" Final Rules for Game Operation (effective May 3, 2011)

Director's Order Number Forty-Two (11)

Virginia's Instant Game Lottery 1271; "Serious Folding Money" Final Rules for Game Operation (effective May 6, 2011)

* * * * * * * *

The following Director's Order of the State Lottery Department was filed with the Virginia Registrar of Regulations on April 27, 2011.

Director's Order Number Thirty-Eight (10)
Certain Virginia Instant Game Lotteries; End of Games.

In accordance with the authority granted by §§ 2.2-4002 B 15 and 58.1-4006 A of the Code of Virginia, I hereby give notice that the following Virginia Lottery instant games will officially end at midnight on April 29, 2011.

Game 1137	Fast 100's
Game 1164	Hit $1,000
Game 1186	10 Times the Money (TOP)
Game 1203	$1,000 Club
Game 1204	Blackjack Showdown (TOP)
Game 1206	Cash Flurry
Game 1210	Lucky Pair
Game 1235	Monopoly (TOP)

The last day for lottery retailers to return for credit unsold tickets from any of these games will be June 3, 2011. The last day to redeem winning tickets for any of these games will be October 26, 2011, 180 days from the declared official end of the game. Claims for winning tickets from any of these games will not be accepted after that date. Claims that are mailed and received in an envelope bearing a postmark of the United States Postal Service or another sovereign nation of October 26, 2011, or earlier, will be deemed to have been received on time. This notice amplifies and conforms to the duly adopted State Lottery Board regulations for the conduct of lottery games.

This order is available for inspection and copying during normal business hours at the Virginia Lottery headquarters, 900 East Main Street, Richmond, Virginia; and at any Virginia Lottery regional office. A copy may be requested by mail by writing to Director's Office, Virginia Lottery, 900 East Main Street, Richmond, Virginia 23219.

This Director's Order becomes effective on the date of its signing and shall remain in full force and effect unless amended or rescinded by further Director's Order.

/s/ Paula I. Otto
Executive Director
April 27, 2011

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Legal Notice - 2011 Reimbursement Methodology Changes

The Virginia Department of Medical Assistance Services (DMAS) hereby affords the public notice of its intention to amend the Virginia State Plan for Medical Assistance to (pursuant to § 1902(a)(13) of the Act) provide for changes to the Methods and Standards for Establishing Payment Rates-Inpatient Hospital Services (12VAC30-70); Methods and Standards for Establishing Payment Rates-Other Types of Care (12VAC30-80); and Methods and Standards for Establishing Payment Rates-Long Term Care (12VAC30-90). DMAS shall implement a number of changes in these reimbursement methodologies effective July 1, 2011, pursuant to Item 297 of the 2011 Appropriation Act.

Reimbursement Changes Affecting Hospitals (12VAC30-70)

12VAC30-70-50 is being amended to restore the efficiency incentive and eliminate the inflation adjustment for long-stay hospitals. This change is mandated by Item 297 AAA of the Appropriation Act and represents an increase in total expenditures of $1,044,204.

12VAC30-70-331 and 12VAC30-70-341 are being amended to restore the reduction to the hospital adjustment factor from 78 to 74% for acute and rehab services and from 84 to 80% for psychiatric services. Corresponding changes will be applied for Type One hospitals. This change is mandated by Item 297 AAAA of the Appropriation Act and represents an increase in total expenditures of $48,328,528.

12VAC30-70-351 is being amended to:

1) Eliminate the inflation adjustment for inpatient hospital operating rates. This change is mandated by Item 297 BBB 1a of the Appropriation Act and represents a cost savings of $93,109,278 in total expenditures.

2) Eliminate the inflation adjustment for inpatient hospital disproportionate share hospital (DSH) payments for all hospitals. This change is mandated by Item 297 BBB 1b of the Appropriation Act and represents a cost savings of $20,952,448 in total expenditures.

3) Eliminate inflation adjustment for graduate medical education (GME) payments for all hospitals. This change is mandated by Item 297 BBB 1c of the Appropriation Act and reflects a cost savings of $5,501,618 in total expenditures.

4) Eliminate inflation adjustment for freestanding psychiatric hospital operating rates. This change is mandated by Item 297 CCC of the Appropriation Act and represents a cost savings of $840,334 in total expenditures.

12VAC30-70-271 is being amended to reduce inpatient capital reimbursement from 75 to 71% of cost with corresponding changes for Type One hospitals and Virginia hospitals with Medicaid utilization greater than 50%. This change is mandated by Item 297 HHHH 2 of the Appropriation Act and represents a cost savings of $5,299,070 in total expenditures.

12VAC30-70-291 is being amended to eliminate Neonatal Intensive Care Unit (NICU) indirect medical education (IME) payments for freestanding children's hospitals and restore NICU IME for hospitals with greater than 50% Medicaid NICU utilization or Medicaid NICU days in excess of 4,500. This change is mandated by Item 297 MMM of the Appropriation Act and represents a cost savings of $1,200,000 in total expenditures.

12VAC30-70-420 is being amended to reduce operating rates for out-of-state non cost-reporting hospitals to the lesser of the home state's reimbursement or the statewide average. This change is mandated by Item 297 ZZZ of the Appropriation Act and represents a cost savings of $5,930,580 in total expenditures.

Reimbursement Changes Affecting Other Providers (12VAC30-80)

12VAC30-80-20 is being amended to reduce outpatient hospital reimbursement from 80 to 76% of cost. Corresponding changes will be applied for Type One hospitals. This change is mandated by Item 297 BBBB 2 of the Appropriation Act and represents a cost savings of $21,604,678 in total expenditures.

12VAC30-80-190 is being amended to restore the reduction to physician rates by 4.0%. This change is mandated by Item 297 CCCC 2 of the Appropriation Act and represents an increase in expenditures of $29,428,550 in total expenditures.

12VAC30-80-30 is being amended to restore dental fees by 4.0%. This change is mandated by Item 297 DDDD 2 of the Appropriation Act and represents an increase in total expenditures of $4,669,680.

12VAC30-80-180 is being amended to eliminate inflation adjustment for home health agencies. This change is mandated by Item 297 FFF of the Appropriation Act and represents a cost savings of $804,262 in total expenditures.

12VAC30-80-200 is being amended to eliminate inflation adjustment for outpatient rehabilitation agencies. This change is mandated by Item 297 GGG of the Appropriation Act and represents a cost savings of $330,992 in total expenditures.

12VAC30-80-30 is being amended to establish supplemental payments for physician practices affiliated with Virginia freestanding children's hospitals. This change is mandated by Item 297 LLLL of the Appropriation Act and represents an increase in total expenditures of $3,900,000.

12VAC30-80-40 is being amended to reduce the maximum reimbursement for pharmaceutical products to average wholesale price minus 13.1%. This change is mandated by Item 297 SSS 2 of the Appropriation Act and represents a cost savings of $2,713,170 in total expenditures.

12VAC30-80-40 is being amended to eliminate the $5.00 per month/per member unit dose dispensing fee for members residing in a nursing facility. The change is mandated by Item 297 NNNN of the Appropriation Act and represents a cost savings of $647,416 in total expenditures.

Reimbursement Changes Affecting Nursing Facilities (12VAC30-90)

12VAC30-90-41 is being amended to eliminate inflation adjustment and freeze ceilings for nursing facilities and specialized care facilities. This change is mandated by Item 297 DDD 1a of the Appropriation Act and represents a cost savings of $36,655,904 in total expenditures.

12VAC30-90-41 is being amended to restore the reduction to nursing facility operating rates by 3.0%. This change is mandated by Item 297 DDD 1d of the Appropriation Act and represents an increase in total expenditures of $27,639,324.

12VAC30-90-36 is being amended to reduce nursing facility capital rental rate floor from 9.0% to 8.0%. This change is mandated by Item 297 DDD 1c of the Appropriation Act and represents a cost savings of $9,876,818 in total expenditures.

This notice is intended to satisfy the requirements of 42 CFR 447.205 and of § 1902(a)(13) of the Social Security Act, 42 USC § 1396a(a)(13). A copy of this notice is available for public review from William Lessard, Provider Reimbursement Division, DMAS, 600 Broad Street, Suite 1300, Richmond, VA 23219, and this notice is available for public review on the Regulatory Town Hall (www.townhall.com). Comments or inquiries may be submitted, in writing, within 30 days of this notice publication to Mr. Lessard and such comments are available for review at the same address.

Contact Information: Brian McCormick, Regulatory Supervisor, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-8856, FAX (804) 786-1680, TDD (800) 343-0634, or email brian.mccormick@dmas.virginia.gov.

DEPARTMENT OF HEALTH PROFESSIONS

Notice of Public Comment Period and Study Related to HB 1559, Exempting Virginia Licensed Audiologists from Hearing Aid Specialists Examination Requirements

Pursuant to Rule 20(1) of the Rules of the Senate of Virginia, the Senate Committee on Education and Health has referred the subject matter contained in House Bill 1559 (2011 Session of the General Assembly) for study by the Department of Professional and Occupation Regulation, in conjunction with the Department of Health Professions. House Bill 1559 would exempt Virginia licensed audiologists who hold a doctoral degree in audiology from all of the current examination requirements, which consists of both a written and practical examination, in order to obtain a Virginia hearing aid specialists license. The departments invite public comment on this issue. This review is being conducted pursuant to § 54.1-310 A 4 of the Code of Virginia. The Department of Professional and Occupational Regulation and the Department of Health Professions welcome written comments on this matter.

The Department of Professional and Occupational Regulation will receive written comments until 5 p.m. on Friday, June 24, 2011, which may be sent to the address below or sent to hearingaidspec@dpor.virginia.gov. Comments or questions should be sent to: William H. Ferguson, Executive Director, Board for Hearing Aid Specialists, Department of Professional and Occupational Regulation, 9960 Mayland Drive, Suite 400, Richmond, VA 23233, telephone (804) 367-8590, or email hearingaidspec@dpor.virginia.gov.

The Department of Health Professions will receive written comments until 5 p.m. on Friday, June 24, 2011, which may be sent to the address below or sent to audbd@dhp.virginia.gov. Comments or questions should be sent to Leslie L. Knachel, Executive Director, Board of Audiology and Speech-Language Pathology, Department of Health Professions, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4630, or email audbd@dhp.virginia.gov.

A public hearing will be held on Thursday, May 26, 2011, 9:30 a.m., at Perimeter Center, Training Room 1, 2nd Floor, 9960 Mayland Drive, Richmond, VA 23233.

STATE WATER CONTROL BOARD

Proposed Consent Order to be Issued by the State Water Control Board to Titan Virginia Ready-Mix LLC and Mechanicsville Concrete LLC, d/b/a Powhatan Ready Mix

Purpose of notice: To seek public comment on a proposed consent order to be issued by the State Water Control Board to Titan Virginia Ready-Mix, LLC and Mechanicsville Concrete LLC, d/b/a Powhatan Ready Mix, regarding their facilities located in Norfolk, Centreville, Clear Brook, and Sterling, Virginia.

Public comment period: May 23, 2011, through June 22, 2011.

Consent order description: The State Water Control Board proposes to issue a consent order to Titan Virginia Ready Mix, LLC and Mechanicsville Concrete, LLC, d/b/a Powhatan Ready Mix, to address violations of the State Water Control Law. The consent order requires the payment of a civil charge and the performance of certain corrective action to address the aforementioned violations.

How to comment: The Department of Environmental Quality (DEQ) accepts comments from the public by email, fax, or postal mail. All comments must be received by DEQ within the comment period. The public may review the proposed consent order at the office named below or on DEQ's website at www.deq.virginia.gov.

Contact for public comments, document requests, and additional information: Kathleen F. O'Connell, Department of Environmental Quality, 629 East Main Street, Richmond, VA 23223, telephone (804) 698-4273, FAX (804) 698-4277, or email kathleen.oconnell@deq.virginia.gov.

VIRGINIA CODE COMMISSION

Notice to State Agencies

Contact Information: *Mailing Address:* Virginia Code Commission, 910 Capitol Street, General Assembly Building, 2nd Floor, Richmond, VA 23219; *Telephone:* Voice (804) 786-3591; FAX (804) 692-0625; *Email:* varegs@dls.virginia.gov.

Meeting Notices: Section 2.2-3707 C of the Code of Virginia requires state agencies to post meeting notices on their websites and on the Commonwealth Calendar at http://www.virginia.gov/cmsportal3/cgi-bin/calendar.cgi.

Cumulative Table of Virginia Administrative Code Sections Adopted, Amended, or Repealed: A table listing regulation sections that have been amended, added, or repealed in the *Virginia Register of Regulations* since the regulations were originally published or last supplemented in the print version of the Virginia Administrative Code is available at http://register.dls.virginia.gov/cumultab.htm.

Filing Material for Publication in the Virginia Register of Regulations: Agencies are required to use the Regulation Information System (RIS) when filing regulations for publication in the *Virginia Register of Regulations*. The Office of the Virginia Register of Regulations implemented a web-based application called RIS for filing regulations and related items for publication in the Virginia Register. The Registrar's office has worked closely with the Department of

Planning and Budget (DPB) to coordinate the system with the Virginia Regulatory Town Hall. RIS and Town Hall complement and enhance one another by sharing pertinent regulatory information.