VIRGINIA REGISTER OF REGULATIONS

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

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

PUBLICATION SCHEDULE AND DEADLINES

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

November 2012 through November 2013

Volume: Issue	Material Submitted By Noon*	Will Be Published On
29:6	October 31, 2012	November 19, 2012
29:7	November 13, 2012 **(Tuesday)**	December 3, 2012
29:8	November 28, 2012	December 17, 2012
29:9	December 11, 2012 **(Tuesday)**	December 31, 2012
29:10	December 26, 2012	January 14, 2013
29:11	January 9, 2013	January 28, 2013
29:12	January 23, 2013	February 11, 2013
29:13	February 6, 2013	February 25, 2013
29:14	February 20, 2013	March 11, 2013
29:150	March 6, 2013	March 25, 2013
29:16	March 20, 2013	April 8, 2013
29:17	April 3, 2013	April 22, 2013
29:18	April 17, 2013	May 6, 2013
29:19	May 1, 2013	May 20, 2013
29:20	May 15, 2013	June 3, 2013
29:21	May 29, 2013	June 17, 2013
29:22	June 12, 2013	July 1, 2013
29:23	June 26, 2013	July 15, 2013
29:24	July 10, 2013	July 29, 2013
29:25	July 24, 2013	August 12, 2013
29:26	August 7, 2013	August 26, 2013
30:1	August 21, 2013	September 9, 2013
30:2	September 4, 2013	September 23, 2013
30:3	September 18, 2013	October 7, 2013
30:4	October 2, 2013	October 21, 2013
30:5	October 16, 2013	November 4, 2013
30:6	October 30, 2013	November 18, 2013

*Filing deadlines are Wednesdays unless otherwise specified.

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARD OF MEDICINE

Agency Decision

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

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

Name of Petitioner: David Weitzman, M.D.

Nature of Petitioner's Request: To amend requirements for licensure for persons who have been duly licensed in another state and have practiced a set number of years to gain unrestricted licensure by reciprocity or other such pathways.

Agency Decision: Request denied.

Statement of Reason for Decision: At its meeting on October 25, 2012, the board denied the petition because its current regulation, requiring at least one year in a residency approved by the American Board of Medical Specialties, is a minimal criteria necessary to ensure competency and protect the public.

Agency Contact: Elaine J. Yeatts, Agency Regulatory Coordinator, Department of Health Professions, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4688, FAX (804) 527-4434, or email elaine.yeatts@dhp.virginia.gov.

VA.R. Doc. No. R13-02, Filed October 26, 2012, 1:15 p.m.

TITLE 8. EDUCATION

STATE BOARD OF EDUCATION

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the State Board of Education intends to consider amending **8VAC20-22, Licensure Regulations for School Personnel.** Chapter 365 of the 2012 Acts of Assembly requires the Board of Education to promulgate regulations establishing licensure requirements for teachers who teach only online courses as defined in § 22.1-212.23 of the Code of Virginia. Such license shall be valid only for teaching online courses. Teachers who hold a five-year renewable license issued by the Board of Education may teach online courses for which they are properly endorsed. As the options available to Virginia's public school students through virtual learning programs continue to expand, requirements for teachers assigned to teach only online courses need to be addressed. The Board of Education's Licensure Regulations for School Personnel do not specifically address requirements for teachers who teach only online courses. The legislation requires the establishment of a license and criteria for obtaining the license.

The agency is seeking comments on this regulatory action, including but not limited to, (i) ideas to be considered in the development of this proposal, (ii) the costs and benefits of any alternatives, and (iii) potential impacts of the regulation. The agency is also seeking information on impacts on small businesses as defined in § 2.2-4007.1 of the Code of Virginia. Information may include (i) projected reporting, recordkeeping and other administrative costs; (ii) the probable effect of the regulation on affected small businesses; and (iii) the description of less intrusive or costly alternatives for achieving the purpose of the regulation.

Anyone wishing to submit comments may do so via the Regulatory Town Hall website (http://www.townhall.virginia.gov), or by mail, email, or fax to Dr. Mark Allan, P.O. Box 2120, Richmond, Virginia 23218-2120, (phone) 804-371-2471, (fax) 804-530-4510. Written comments must include the name and address of the commenter. In order to be considered, comments must be received by midnight on the last day of the public comment period.

A public hearing will be held following the publication of the proposed stage of this regulatory action and notice of the hearing will be posted on the Virginia Regulatory Town Hall website (http://www.townhall.virginia.gov) and on the Commonwealth Calendar website (http://www.virginia.gov/cmsportal3/cgi-bin/calendar.cgi). Both oral and written comments may be submitted at that time.

At this time, it is not anticipated that this change in the regulations will be controversial.

Statutory Authority: § 22.1-298.1 of the Code of Virginia.

Public Comment Deadline: December 19, 2012.

Agency Contact: Patty S. Pitts, Assistant Superintendent for Teacher Education and Licensure, Department of Education, P.O. Box 2120, Richmond, VA 23218, telephone (804) 371-2522, or email patty.pitts@doe.virginia.gov.

VA.R. Doc. No. R13-3427; Filed October 31, 2012, 9:19 a.m.

TITLE 13. HOUSING

BOARD OF HOUSING AND COMMUNITY DEVELOPMENT

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the Board of Housing and Community Development intends to consider amending **13VAC5-21, Virginia Certification Standards.** The purpose of the proposed action is to update the regulation to coordinate with the building and fire regulations of the department that are being updated to reference the newest available nationally recognized model codes and standards. Since the national codes are so comprehensive in their scope, the agency will accept comment on all provisions of the regulation to insure compatibility with the latest codes.

The agency is seeking comments on the intended regulatory action, including but not limited to (i) ideas to assist in the development of a proposal, (ii) the costs and benefits of the alternatives stated in this background document or other alternatives, and (iii) potential impacts of the regulation. The agency is also seeking information on impacts on small businesses as defined in § 2.2-4007.1 of the Code of Virginia. Information may include (i) projected reporting, recordkeeping, and other administrative costs; (ii) probable effect of the regulation on affected small businesses; and (iii) description of less intrusive or costly alternative methods of achieving the purpose of the regulation.

Anyone wishing to submit written comments may do so at the public hearing or by mail, email, or fax to Steve Calhoun, 600 East Main Street, Suite 300, Richmond, VA 23219-1321, (804) 371-7015, fax number: (804) 371-7092, email address: steve.calhoun@dhcd.virginia.gov. Written comments must include the name and address of the commenter. In order to be considered, comments must be received by the last day of the public comment period.

In addition, the agency is seeking information on (i) the continued need for the regulation; (ii) the complexity of the regulation; (iii) the extent to the which the regulation overlaps, duplicates, or conflicts with federal or state law or

regulation; and (iv) the length of time since the regulation has been evaluated or the degree to which technology, economic conditions, or other factors have changed in the area affected by the regulation.

A public hearing will be held and notice of the hearing may be found on the Virginia Regulatory Town Hall website (http://www.townhall.virginia.gov) and on the Commonwealth Calendar website (http://www.virginia.gov/cmsportal3/cgi-bin/calendar.cgi). Both oral and written comments may be submitted at that time.

Statutory Authority: § 36-137 of the Code of Virginia.

Public Comment Deadline: December 19, 2012.

Agency Contact: Stephen W. Calhoun, Regulatory Coordinator, Department of Housing and Community Development, Main Street Center, 600 East Main Street, Suite 300, Richmond, VA 23219, telephone (804) 371-7000, FAX (804) 371-7090, TTY (804) 371-7089, or email steve.calhoun@dhcd.virginia.gov.

VA.R. Doc. No. R13-3407; Filed October 18, 2012, 10:07 a.m.

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007.01 of the Code of Virginia that the Board of Housing and Community Development intends to consider amending **13VAC5-80, Virginia Standards for Individual and Regional Code Academies.** The purpose of the proposed action is to update the requirements for local code academies to reflect current practices of the Virginia Building Code Academy for consistency in the operation of the state and local academies and to clarify reporting and assurance requirements for the local academies to ensure compatible courses and practices.

The agency is seeking comments on this regulatory action, including but not limited to, (i) ideas to be considered in the development of this proposal, (ii) the costs and benefits of the alternatives stated in this background document or other alternatives, and (iii) potential impacts of the regulation. The agency is also seeking information on impacts on small businesses as defined in § 2.2-4007.1 of the Code of Virginia. Information may include (i) projected reporting, recordkeeping, and other administrative costs; (ii) the probable effect of the regulation on affected small businesses; and (iii) the description of less intrusive or costly alternatives for achieving the purpose of the regulation.

Anyone wishing to submit comments may do so via the Regulatory Town Hall website (http://www.townhall.virginia.gov), or by mail, email, or fax to Steve Calhoun, 600 East Main Street, Suite 300, Richmond, VA 23219, (804) 371-7150, fax number: (804) 371-7092, email address: steve.calhoun@dhcd.virginia.gov Written comments must include the name and address of the commenter. In order to be considered, comments must be received by midnight on the last day of the public comment period.

A public hearing will be held prior to and following the publication of the proposed stage of this regulatory action and notice of the hearing will be posted on the Virginia Regulatory Town Hall website (http://www.townhall.virginia.gov) and on the Commonwealth Calendar website (http://www.virginia.gov/cmsportal3/cgi-bin/calendar.cgi). Both oral and written comments may be submitted at that time.

Statutory Authority: §§ 36-137 and 36-139 of the Code of Virginia.

Public Comment Deadline: December 19, 2012.

Agency Contact: Stephen W. Calhoun, Regulatory Coordinator, Department of Housing and Community Development, Main Street Center, 600 East Main Street, Suite 300, Richmond, VA 23219, telephone (804) 371-7000, FAX (804) 371-7090, TTY (804) 371-7089, or email steve.calhoun@dhcd.virginia.gov.

VA.R. Doc. No. R13-3470; Filed October 31, 2012, 10:18 a.m.

REGULATIONS

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

Symbol Key

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

TITLE 1. ADMINISTRATION

DEPARTMENT OF GENERAL SERVICES

Final Regulation

REGISTRAR'S NOTICE: The Department of General Services is claiming an exemption from the Administrative Process Act in accordance with § 2.2-4006 A 3, which excludes regulations that consist only of changes in style or form or corrections of technical errors. The Department of General Services will receive, consider, and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: **1VAC30-80. Rules and Regulations Governing the Handling of Forensic Work - Division of Forensic Science (repealing 1VAC30-80-10, 1VAC30-80-20).**

Statutory Authority: § 2.2-1102 of the Code of Virginia.

Effective Date: December 19, 2012.

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

Summary:

Chapter 154 of the 1996 Acts of Assembly transferred the Division of Forensic Science from the Department of General Services to the Department of Criminal Justice Services. Because the Department of General Services no longer has authority for this regulation, it is repealed.

VA.R. Doc. No. R13-3423; Filed October 24, 2012, 1:36 p.m.

TITLE 4. CONSERVATION AND NATURAL RESOURCES

DEPARTMENT OF CONSERVATION AND RECREATION

Final Regulation

REGISTRAR'S NOTICE: The Department of Conservation and Recreation is claiming an exemption from the Administrative Process Act in accordance with § 2.2-4006 A 1 of the Code of Virginia, which excludes agency orders or regulations fixing rates or prices. The Department of Conservation and Recreation will receive, consider, and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: **4VAC5-36. Standard Fees for Use of Department of Conservation and Recreation Facilities, Programs, and Services (amending 4VAC5-36-50, 4VAC5-36-90, 4VAC5-36-110, 4VAC5-36-130, 4VAC5-36-140, 4VAC5-36-150, 4VAC5-36-160, 4VAC5-36-180, 4VAC5-36-190, 4VAC5-36-200).**

Statutory Authority: § 10.1-104 of the Code of Virginia.

Effective Date: January 1, 2013.

Agency Contact: David C. Dowling, Policy, Planning, and Budget Director, Department of Conservation and Recreation, 203 Governor Street, Suite 302, Richmond, VA 23219, telephone (804) 786-2291, FAX (804) 786-6141, or email david.dowling@dcr.virginia.gov.

Summary:

The amendments alter fees in the following areas: parking and launch fees (4VAC5-36-50); camping fees (4VAC5-36-90); picnic shelters and event tents fees (4VAC5-36-110); boat storage fees (4VAC5-36-130); interpretative canoe, boat, and paddleboat fees (4VAC5-36-140); interpretive and educational tours and program fees (4VAC5-36-150); outdoor skill program fees (4VAC5-36-160); state park performing arts events fees (4VAC5-36-180); environmental education center fees (4VAC5-36-190); and miscellaneous rental fees (4VAC5-36-200).

Increases and changes to these State Park System standard fees represent revisions to reflect: (i) increased fees for special events as requested by the event organizers; (ii) the addition of new offerings (i.e., Occoneechee boat storage fees); (iii) the deletion of fees that have become obsolete as there is no longer demand for a service; (iv) changes to maintain fair market value and demand for service; and (v) updates to ensure formatting consistency.

4VAC5-36-50. Parking and launch fees.

PARKING FEES (NONTAXABLE)

	WEEKDAYS	WEEKENDS
Daily Parking for Passenger Vehicles: Applies to cars, trucks, vans (up to 15 passenger), and motorcycles.		
All parks unless listed below.	$2.00	$3.00
Parks under construction and having only limited facilities and services.	$2.00	$2.00
Fairy Stone, Raymond R. "Andy" Guest Jr. Shenandoah River, Smith Mountain Lake, Claytor Lake, Kiptopeke, Westmoreland, Mason Neck, Sky Meadows, Chippokes	$3.00	$4.00
Leesylvania, First Landing, Lake Anna, Pocahontas	$4.00	$5.00
York River Croaker Landing/Pier Area (also requires boat launch fee for all vehicles)	$3.00	$3.00
Horse Trailer Parking Fee covers up to two horses in the same trailer (also requires vehicle parking fee.) All parks unless listed below.	$3.00 per trailer	$3.00 per trailer
Lake Anna	$4.00 per trailer	$4.00 per trailer
Surcharge for additional horse in same trailer beyond the first two horses.	$2.00 per horse	$2.00 per horse
Other Trailer Parking Fee: Applies to other trailers not covered by camping, horse trailer, and boat launch fee. (Add to daily parking fee.)	$2.00 per trailer	$2.00 per trailer
Daily Bus Parking: All Seasons. Applies to vehicles with 16 or more passenger capacity.		
All parks unless listed below.	$10	$10
Claytor Lake, Hungry Mother, Leesylvania, Mason Neck, New River Trail	$12	$12
First Landing, Kiptopeke, Lake Anna, Pocahontas, Westmoreland	$15	$15
Natural Area Preserve Parking Fees for any Vehicle: The department may charge these fees at any Natural Area Preserve.	$2.00	$2.00
Boat Launch Fees: Required to use park boat ramps on bodies of water where motorboats are permitted. Required for all vehicles using York River Croaker Landing/Pier Area. May not apply to small "car-top" launch facilities (facilities at which boats may only be launched by hand carrying them to the water). The fee is normally added to the parking fee to create a combined park/launch payment.		
Daily Launch Fees: All Seasons		
All parks unless listed below.	$3.00	$3.00
Claytor Lake	$2.00	$2.00
First Landing, Kiptopeke (with Marine Fishing License), Lake Anna	$4.00	$4.00

Kiptopeke (without Marine Fishing License), Leesylvania	$8.00	$8.00
Surcharge for second boat on same trailer: jet ski	$2.00	$2.00
Overnight parking at boat launch: where available	$10	$10
Camper's Boat Launch Fee Kiptopeke: Does not apply if camper parks trailer at campsite.	$3.00	$3.00
Boat Tournament Fee for Fishing Tournaments: Registration fee is based on the number of boats registered and is nonrefundable regardless of number that actually participates. This fee is in addition to the applicable daily launch fee.	No charge	$2.00 per boat

Annual and Lifetime Parking Fees:	FEE
Lifetime Naturally Yours Passport Plus: Lifetime admission and parking pass to all state parks, plus 10% discount on individual camp sites and horse stalls; all state park merchandise, except fuel sales; equipment rentals; and shelter rentals except where these services are provided by private concessionaires.	
Age up to 40	$333
Age 41-45	$300
Age 46-50	$266
Age 51-55	$233
Age 56−61	$200
Senior Lifetime Naturally Yours Passport Plus (Age 62 or older): See Lifetime Naturally Yours Passport Plus above.	$121
Naturally Yours Passport Plus: 12-month from date of purchase admission and parking pass to all state parks, plus 10% discount on camping, all state park merchandise, equipment rentals, and shelter rentals.	$66
Naturally Yours Parking Passport: 12-month from date of purchase admission and parking pass to park of purchase.	$40
Senior Naturally Yours Passport Plus: See Naturally Yours Passport Plus above.	$36
Senior Naturally Yours Parking Passport: See Naturally Yours Parking Passport above.	$24
Golden Disability Pass: Available to persons with disabilities as verified by U.S. Social Security Administration's (SSA) "Benefit Verification Letter." Pass remains in effect unless SSA withdraws eligibility.	No Charge
Disabled Veterans Passport Admission, parking, and launch pass to all state parks, plus 50% discount on camping fees, swimming fees, shelter rentals, and department equipment rentals when provided by the department. Where equipment rentals are provided by private concessionaires, this passport does not apply. The passport shall be issued upon request to a veteran of the armed forces of the United States with a letter from the U.S. Department of Veterans Affairs, or from the military service that discharged the veteran, certifying that such veteran has a service-connected disability rating of 100%. This passport coverage shall be valid for as long as that determination by the U.S. Department of Veterans Affairs remains in effect.	No Charge

Annual and Lifetime Park/Launch/Equestrian Fees:	
Lifetime Naturally Yours Passport Plus for Boaters and Equestrians: Lifetime admission, parking, and launch pass to all state parks, plus 10% discount on camping, all state park merchandise, equipment rentals, and shelter rentals.	
Age up to 40	$667
Age 41-45	$600
Age 46-50	$534
Age 51-55	$466
Age 56-61	$400
Senior Lifetime Naturally Yours Passport Plus for Boaters and Equestrians (Age 62 or older): See Lifetime Naturally Yours Passport Plus for Boaters above.	$345
Naturally Yours Passport Plus for Boaters and Equestrians: 12-month from date of purchase admission, parking, and launch pass to all state parks, plus 10% discount on camping, all state park merchandise, equipment rentals, and shelter rentals.	$167
Park/Launch/Equestrian Passport:	
12-month from date of purchase admission, parking, and launch pass to all state parks including Leesylvania.	$141
12-month from date of purchase admission, parking, and launch pass to First Landing, Kiptopeke, or Lake Anna. Good only at park of purchase.	$107
12-month from date of purchase admission, parking, and launch pass to park of purchase other than Leesylvania, First Landing, Kiptopeke, or Lake Anna.	$87
Senior Naturally Yours Passport Plus for Boaters and Equestrians: Annual permit for all parks including Leesylvania.	$133
Senior Park/Launch/Equestrian Passport:	
12-month from date of purchase admission, parking, and launch pass to all state parks including Leesylvania.	$120
12-month from date of purchase admission, parking, and launch pass to First Landing, Kiptopeke, or Lake Anna. Good only at park of purchase.	$87
12-month from date of purchase admission, parking, and launch pass to park of purchase other than Leesylvania, First Landing, Kiptopeke, or Lake Anna.	$73
Buggs Island Lake Special Annual Park/Launch/Equestrian Pass: Good only at Occoneechee and Staunton River State Parks.	$55
Leesylvania Annual Overnight Boating/Parking Pass.	$74
Disabled Visitor Annual Boat Launch Pass (in addition to disabled tags).	$48

Special Event Fees:	EVENT FEE
Standard Special Event Parking Fee: Applies to all parks and events that utilize parking fees unless noted below.	$10 per vehicle

Community Event Fee: May be used by any park as a condition of a Special Use Permit for a community event provided by a nonprofit group or organization or government agency or entity.	$1.00 per vehicle
Sky Meadows: Strawberry Festival	
Advance payment	~~$15~~ $20 per vehicle
Day of Event	~~$20~~ $25 per vehicle
Sky Meadows: Extended Hours Special Event: for events that take place after park hours such as Astronomy Night, Candlelight Tours, etc.	$5.00 per vehicle
Grayson Highlands Fall Festival. Hungry Mother Arts and Crafts Festival	$6.00 per vehicle
Claytor Lake Arts and Crafts Festival	$5.00 per vehicle with canned food donation on designated day $10 per vehicle
Kiptopeke: Eastern Shore Birding Festival	Parking Fee waived to registered festival guests; otherwise standard fees apply
Smith Mountain Lake: special park/launch rate for boaters participating in fishing tournaments if the tournament sponsor has also rented the Tournament Headquarters Building.	$5.00 per vehicle/ boat combination
Shenandoah River: Riverfest Event	$8.00 per vehicle
Standard Special Event Per Person Entrance Fee: Applies to all parks and events that utilize per person admission fees unless noted below.	$4.00 per adult $3.00 per child, 6 through 12 years Children under 6 free
Sailor's Creek Battlefield: Battle of Sailor's Creek Reenactment	$5.00 per person Children under 6 free $10 maximum per vehicle $50 per bus (16 passenger +)
Chippokes Plantation Steam and Gas Engine Show	$5.00 per person Children under 12 free
Chippokes Plantation Christmas	$5.00 per person
Chippokes Pork, Peanut & Pine Festival	$5 per person Children under 13 free
Grayson Highlands Wayne C. Henderson Music Festival	$10 per person Children under 12 free
Natural Tunnel Special Event Parking Fee	$2.00 per person $6.00 per vehicle

Occoneechee Pow Wow	$5.00 per person (13 years and older) $3.00 per child, 3 through 12 years $3.00 Seniors (62 and over) Children under 3 free
Occoneechee Pow Wow School Groups	$4.00 per student Teachers and Chaperones free

Notes on parking fees:

1. Weekend rates apply on Memorial Day, Fourth of July, and Labor Day holidays.

2. Except as otherwise noted, boat launching shall be free for up to one boat per vehicle per campsite, cabin, lodge, camping cabin, travel trailer, or camping lodge.

3. Parking fees are waived for any vehicle displaying disabled license plates or temporary disabled parking identification issued by any state or the federal government. However, the fee for any additional types of trailers, the boat launch fee or the portion of any combined parking-launching fee that applies to boat launching shall be collected from such vehicles. Additionally, the price for annual passes and lifetime passes that include boat launching for qualified disabled individuals shall be calculated by subtracting the applicable parking pass fee from the park/launch pass fee.

4. Parking fees are waived for any vehicle occupied solely by students and/or teachers and/or assisting personnel participating in an official activity of a bona fide school, home school, or institution of higher learning. Parks may require that individuals in vehicles other than those marked as a school bus verify their official activity by letter from the school or approved field trip form, or in the case of home school groups, proof of home school status such as current ID card from a state or national home school organization (HEAV, HSLDA, etc.) or a copy of the letter from the school district that acknowledges "Notice of Intent" to home school for that school year.

5. Parking fees are waived for official vehicles of federal, state, and local governments while on official business; vehicles making deliveries to the park; contractor and business vehicles performing work in the park; and emergency vehicles while conducting official business, including training.

6. Parking fees are waived for park employees during time of employment, including family and household members of staff occupying staff residences, visitors to staff residences, and park volunteers entering the park to perform volunteer duties.

7. Parking fees may be waived for vehicles conducting research or collecting activities provided such waiver is included in the language of the Research and Collection Permit as required in 4VAC5-30-50.

8. The period covered by a daily parking fee shall be midnight to midnight. Park guests utilizing overnight parking when and where available (e.g., backpackers, overnight fishermen, etc.) will be required to pay the applicable daily parking fee for each calendar day that their vehicle is in the parking lot (partial days included).

9. Annual permits shall be valid for 12 months from the date of purchase, unless otherwise noted.

10. Parking fees are waived for visitors entering the park for the sole purpose of dining at the park restaurant at Douthat and Hungry Mother State Parks.

11. Parking fees are waived at state parks for participants in Walk for Parks, Fall River Renaissance, Envirothons, March for Parks, Operation Spruce-Up Day, Stewardship Virginia, National Trails Day, and other park-sanctioned public service events as approved by the director.

12. Daily parking fees are reduced to $1.00 for vehicles occupied by participants in fund-raising events sponsored by nonprofit organizations (Walk-A-Thons, etc.) provided the sponsor has obtained a special use permit from the park that contains provisions for the identification of participants in the event.

13. Parking fees shall be waived for persons using park roads to gain legal access to their private residence and guests to such residences; and for vehicles passing through, but not stopping in, a park on a public roadway.

14. Revenue collected from special event parking and/or admission fees may be divided between the park and the event sponsor if so designated and approved in the special event permit following a determination made by the director that the revenue split is in the benefit of the Commonwealth.

15. Annual Park/Launch/Equestrian passes cover the park entrance or parking fee for up to two horses in the same horse trailer or other allowable trailers. Annual and Lifetime parking-only passes do not include trailers.

16. Parking fees are waived for service vehicles such as tow trucks when entering the park to service a visitor vehicle.

17. Parking fees are waived for visitors entering the park to attend a performance by a U.S. military band if this is a required condition for the band's performance.

18. Parking fees are included in the rental fees for meeting facilities, up to the capacity of the facility and provided that this waiver of fee is included in the rental agreement for the facility.

19. Parking fees are waived for a period of up to 15 minutes for persons entering the park to deposit materials in community recycling collection containers.

20. Parking fees are waived for vehicles occupied entirely by persons attending fee interpretive programs.

21. Annual parking passes that do not include boat launch require payment of daily launch fee if launching a boat at any park or for all vehicles using Croaker Landing/Pier Area at York River State Park.

22. Annual parking pass holders are not guaranteed the parking privileges of the pass should parking places be unavailable.

23. Parking fees are waived at Mason Neck during the park's annual Elizabeth Hartwell Eagle Festival.

24. The payment of a parking fee at one park shall be applied to parking at any state park on the same day provided that the visitor supplies evidence of the paid parking fee.

25. Annual passes are issued to the purchaser and members of the same household and may not be transferred. Improper transfer or use may result in revocation of the pass without refund.

26. Parking fees are waived at all state parks on Veterans Day, November 11, of each year.

4VAC5-36-90. Camping fees.

CAMPING FEES (TAXABLE, Price here does not include tax)

Camping fees include free use of dump station and free swimming and boat launching for members of the camping party during their stay at the property, when and where available, except that at Kiptopeke State Park guest is subject to applicable launch fee unless the trailer is returned to the campsite immediately after launching. The number of campers per campsite is limited to six individuals except when all campers are members of the same household.	ALL SEASONS (Per site fees)
Standard Sites: No hookup; access to bathhouse and restrooms.	
All parks with standard sites unless noted below.	$20 per night
Occoneechee Waterfront Sites.	$23 per night
Kiptopeke, First Landing, Lake Anna.	$24 per night
Douthat.	$26 per night
Water and Electric Sites: Access to water and electric hookups; access to bathhouse and restrooms.	
All parks where available unless noted below, including Chippokes Campground A.	$27 per night
Occoneechee Waterfront Sites and Chippokes Campground B.	$30 per night
Kiptopeke, First Landing, Lake Anna, Shenandoah.	$32 per night
Water, Electric, and Sewage Sites: Access to water, electric, and sewage hookups; access to bathhouse and restrooms.	
Kiptopeke.	$37 per night
Hungry Mother.	$30 per night
Primitive Camping Sites: primitive restrooms; no showers.	

All parks where available unless noted below.	$11 per night
James River.	$13 per night
Grayson Highlands: Sites with electricity (November, March and April when bathhouses are closed).	$15 per night
Occoneechee (persons renting the entire equestrian campground will receive a 10% discount on the combined price for sites and stalls, including transaction fees).	$15 per night
New River Trail Primitive camping sites at Foster Falls and Cliffview, Primitive Sites at Sky Meadows.	$15 per night
New River Trail Water Trail Camping (no potable water).	$12 per night
Horse Camping	
Horse Stall Fee.	$7.00 per night (Outside Stalls) $9.00 per night (Inside Stall)
Standard Rates	
Primitive Group Camp Rental (camping in special primitive group areas). All parks where available.	
Up to 20 campers.	$61 for entire area per night
Up to 30 campers.	$91 for entire area per night
31 or more campers, up to maximum capacity of group camp area.	$122 for entire area per night
Grayson Highlands: Primitive camping is available in the stable area November, March, and April.	$15 per site per night
Special Group Camping Areas:	
Fairy Stone Group Campsites.	$20 per site per night
Chippokes Plantation: All 4 Sites; Group Rate; 24 persons maximum. Natural Tunnel Group Area. Grayson Highlands Group Area. James River Group Area. Shenandoah Group Area. Sky Meadows Group Area.	$67 per night (only available as entire group area)
Sky Meadows 6 Site Group Area.	$100 per night
Westmoreland Group Area.	$122 per night
Standard Buddy Sites: All parks where available unless noted below.	$78 per night
Douthat Buddy Sites. Holliday Lake Group Camp.	$97 per night
James River Equestrian Group Area (persons renting the entire equestrian campground will receive a 10% discount on the combined price for sites and stalls, including transaction fees).	$216 per night

Camping – Other Fees	
Camping Site Transaction Fee: Applies to each purchase transaction of a camping visit to a campsite (i.e., one transaction fee per camping visit per site no matter how many nights). Applies to Internet, reservation center, and walk up visits.	$5.00
Dog Fees (this fee does not apply to service or hearing dogs identifiable in accordance with § 51.5-44 of the Code of Virginia).	$5.00 per dog per night, $15 maximum per dog per trip
Dump Station Fee: Free to state park campers during stay.	$5.00 per use
Camping Reservation Cancellation Fee Individual Site.	$10 per reservation
Camping Reservation Cancellation Fee Group Sites.	$30 per reservation
Hiker or noncamper Shower Fee at Virginia State Parks.	$5.00 per person
Sky Meadows: Wheelbarrow Rental Fee for hike-in campers	$10 per wheelbarrow rented

Notes on camping:

1. Check-out time is 3 p.m. and check-in time is 4 p.m.

2. Camping Transfer/Cancellation/Early Departure Policy.

a. Any fees to be refunded are calculated less the applicable cancellation fee(s).

b. Fees paid to the reservation center by credit card will be refunded to the original credit card charged.

c. Fees paid by check or money order to the reservation center, or by any method at the park, will be refunded by state check.

d. A customer may move a camping reservation to another date or park, referred to as a transfer, through the reservation center only, and prior to 4 p.m. on the scheduled date of arrival. If the reservation center will not be open again prior to the start date of the reservation, transferring is not an option. There is no fee to transfer.

e. A camping reservation may be canceled until 4 p.m. on the scheduled date of arrival but campers will be charged the cancellation fee. This cancellation fee applies to each separate reservation made.

f. Once the 4 p.m. check-in time is reached on the scheduled day of arrival, any adjustment to a reservation is considered an early departure.

g. After the check-in time is reached, the first night is considered used whether the site is occupied or not.

h. There is a one-night penalty, deducted from any amount available for refund, for early departure.

3. Campers are allowed two vehicles per campsite per day without charge of a parking fee. Additional vehicles, beyond two, must pay the prevailing parking fee in effect at the park for each day that the vehicle(s) is parked in the park. The number of vehicles allowed to park on the campsite varies according to site design and size of other camping equipment. No vehicles shall park on a campsite in other than the designated area for this purpose. Camper vehicles that do not fit on the site, whether or not they require the special camper vehicle fee, must park in the designated overflow parking area.

4. Each member of the camping party, except in primitive group areas, up to the maximum allowable per site, may receive an entrance pass to the park's swimming facility on the basis of one pass per night of camping. Passes only issued during days and seasons of operation of the swimming facility and only good during the member's registered stay.

5. Damage to campsites, not considered normal wear and tear, will be billed to the person registered for the campsite on an itemized cost basis.

6. At honor collection sites, the stated camping fees on this list shall be considered as having tax included. Honor collection is defined as the payment of the camping fee on-site at the park at a nonelectronic collection point at which the payment is placed in a box or safe provided for that purpose.

7. Horse stalls may only be rented in conjunction with the rental of a campsite in the equestrian campground and a person must occupy the campsite. All horses brought to the park by overnight guests must be kept in rental stalls except in primitive equestrian areas at New River Trail and James River State Parks.

4VAC5-36-110. Picnic shelters and event tents fees.

PICNIC SHELTERS AND EVENT TENTS (TAXABLE)

The shelter rental periods shall be from park opening until park closing, unless otherwise specified.	DAY
Standard Small Picnic Shelter Rental Fee: Bear Creek Lake, Belle Isle, Caledon, Chippokes Plantation, Claytor Lake, Douthat, Holliday Lake, Hungry Mother (half shelter), Lake Anna, Natural Tunnel, New River Trail, Occoneechee, Pocahontas, Sky Meadows, Smith Mountain Lake, Twin Lakes, Westmoreland, York River, and all other small park picnic shelters.	$60
Standard Large Picnic Shelter Rental Fee: Belle Isle, Chippokes Plantation, Claytor Lake, Douthat Fairy Stone, First Landing, Grayson Highlands, Hungry Mother (full shelter), James River, Kiptopeke, Lake Anna, Natural Tunnel, Occoneechee, Pocahontas, Shenandoah, Sky Meadows, Smith Mountain Lake (Pavilion), Staunton River, Staunton River Battlefield, Twin Lakes, Westmoreland, York River, and all other large park picnic shelters.	$90
Leesylvania Shelter, Shenandoah Large Group Shelter Rental	$130
Leesylvania: Lee's Landing Picnic Area Rental	$64
Leesylvania: Lee's Landing Picnic Shelter	$400
With 15 tables and 100 chairs	$820
Mason Neck Picnic Area Rental	
Without tent shelter	$64
With tent shelter (seasonably available)	$130
Chippokes Plantation Conference Shelter (with kitchen)	$315 per function
Chippokes Plantation Conference Shelter kitchen cleaning fee (only applicable is kitchen is used and not cleaned in accordance with rental agreement)	$150 per function
Mini-Shelter: All parks where available unless otherwise noted.	$21
Event Tent Rental: Full day in-park rental only. Price includes set up and take down.	
Standard fee: All parks where available unless otherwise noted.	$0.45 per square foot
Chippokes Plantation, Douthat, Kiptopeke, Lake Anna, Pocahontas, Shenandoah River, Smith Mountain Lake, York River.	$0.55 per square foot
False Cape, First Landing, Leesylvania, Mason Neck.	$0.60 per square foot
Standard 10' x 10' event tent	$25 per day
Westmoreland, Caledon Natural Area: 20' x 40' tent with tables and chairs	$400 per day
Wilderness Road: 20' x 40'	$350 per day
White String Lights for Tent	$0.80 per foot
Side Panels for Tent	$1.50 per foot
Standard Shelter Cancellation Fee: Cancellation fee deducted from refund if refund is made more than 14 days prior to the reservation date. No refunds if cancellation made within 14 days prior to date. Shelter reservation may be transferred without penalty if the change is made through the reservations center prior to scheduled use.	$10

4VAC5-36-130. Boat storage fees.

BOAT STORAGE (TAXABLE, Price here does not include tax)

Boat Storage Fees	FEE

Standard Annual Boat Storage Fee: Bear Creek Lake, Douthat, Hungry Mother, and all other parks where available unless noted below.		$35
Marine Pump-Out Fee (all parks where available)		$5.00 per usage
Leesylvania Boat Storage Fees: Annual Fee (Dec. 1 – Nov. 30). Fee prorated for partial year on a months-remaining basis. Fee includes one park/launch pass per storage rental space to coincide with the rental period.		
Boat Length Up To 16'		$755
Boat Length Up To 17'		$800
Boat Length Up To 18'		$850
Boat Length Up To 19'		$895
Boat Length Up To 20'		$945
Boat Length Up To 21'		$990
Boat Length Up To 22'		$1,035
Boat Length Up To 23'		$1,085
Boat Length Up To 24'		$1,155
Boat Length Up To 25'		$1,210
Leesylvania Canoe/Kayak Storage: Renter must possess an annual parking pass		$10 per month
Staunton River Boat Shed Fees: Does not include parking or launching fee, if applicable		
Nightly Storage		$4.00
Monthly Storage		$15
Six-Month Storage		$70
One-year boat storage		$120 without annual park/launch pass $150 with Buggs Island Special pass
Claytor Lake: Boat Dock Slips:	FEE PER RENTAL SEASON	FEE PER RENTAL NIGHT
7' wide and under	$468	$11
9' wide and under	$715	$22
14' wide and under	$908	$22
Extended length slips	$770	NA
Occoneechee:	FEE PER ANNUAL RENTAL PERIOD	FEE PER RENTAL NIGHT (Transient)
20' with water - 20 amp hookup	$1,200	$36
30' with water - 20 amp hookup	$1,600	NA
30' with water - 20 amp and 30 amp hookups	$1,750	NA

Notes on Occoneechee marina fees/Claytor Lake board dock slips:

1. All rentals for more than a three-month period shall be made by signing an annual rental agreement.

2. The annual rental period shall be March 1 through November 1 at Claytor Lake State Park and through the last day of February in the following year in Occoneechee State Park. All annual rental agreements, no matter when initiated, will end on the last day of an annual period (not 12 months from the time rental).

3. Any annual rental agreement entered into or renewed for a period that includes March 1 through June 30 shall be made at 100% of the annual rental fee.

4. Any annual rental agreement made for a period that includes July 1 through the end of the annual rental period shall receive a 40% discount off of the current annual rate.

5. At the park manager's discretion, and subject to availability, boat slips not covered by an annual rental agreement may be rented on a monthly basis, not to exceed three months to the same renter or boat, at a monthly rate of 20% of the annual rental fee.

6. The cancellation fee for an annual slip rental is three months rental. Also, after the first of the month, that month is considered to be "used."

4VAC5-36-140. Interpretive canoe, boat, and paddleboat fees.

INTERPRETIVE CANOE, BOAT, AND PADDLEBOAT PROGRAMS (NONTAXABLE)

Interpretive Canoe, Boat, and Paddleboat Tours:	FEE
Environmental Education Group Canoe Tour: Available only to bona fide educational groups. Requires previous reservation and arrangements. Minimum 10 persons. Mason Neck and all other parks where available unless otherwise noted.	$3.00 per person
Standard Canoe Interpretive Tour Fee for Individuals: Applies to canoe, rowboat, or paddleboat tours. Child riding as third passenger, where allowed, is free.	
Individuals at all parks unless noted below.	$5.00 per person
Individuals at Leesylvania, York River, Pocahontas, Kiptopeke, Chippokes.	$9.00 per person
Individuals at Mason Neck.	$15 per person
Individuals at Natural Tunnel.	$15 per person
Individuals at False Cape: Back Bay Interpretive Tour.	$16 per person
Family Groups at all parks unless noted below. Minimum 4 paying customers.	$4.00 per person
Family Groups at Leesylvania, Pocahontas, York River, Kiptopeke. Minimum 4 paying customers.	$6.00 per person
Family Groups at Mason Neck.	$9.00 per person
Group rate at Natural Tunnel (minimum 10 paying customers).	$12 per person
Sunset, Moonlight, Dawn, or Extended Canoe Interpretive Tour Fee for Individuals: Applies to canoe, rowboat, or paddleboat tours.	
All parks where offered unless noted below.	$6.00 per person
Sunset, Dawn, Extended Canoe Interpretive Tour Fee for Individuals: Leesylvania, York River, Chippokes, Kiptopeke.	$11 per person
Sunset, Dawn, Extended Canoe Interpretive Tour Fee for Individuals: New River Trail, Mason Neck.	$15 per person
Extended Canoe Interpretive Tour Fee for Individuals: Grayson Highlands, Hungry Mother, New River Trail, Natural Tunnel.	$25 per person
Moonlight/Night Canoe Interpretive Tour Fee for Individuals: Leesylvania, York River, Chippokes.	$13 per person

Moonlight/Night Canoe Interpretive Tour Fee for Individuals: Mason Neck.	$20 per person
Sunset, Moonlight, Dawn, or Extended Canoe Interpretive Tour Fee for Family Groups: Applies to canoe, rowboat, or paddleboat tours. Minimum four paying customers.	
All parks where offered unless otherwise noted.	$5.00 per person
Sunset, Dawn, or Extended Canoe Interpretive Tour Fee for Family Groups: Leesylvania, York River, Chippokes. Requires 4 or more paying customers.	$7.00 per person
Sunset, Dawn, or Extended Canoe Interpretive Tour Fee for Family Groups: New River Trail, Mason Neck.	$11 per person
Moonlight/Night Canoe Interpretive Tour Fee for Family Groups: Leesylvania, York River. Requires 4 or more paying customers.	$8.00 per person
Extended Canoe Interpretive Tour Fee for Family Groups: Grayson Highlands.	$25 per person
Bear Creek Lake: Willis River Interpretive Canoe Tour	
Short Trip.	$8.00 per person
Long Trip.	$10 per person
Natural Tunnel Clinch River:	
Half-Day Trip Group Rate. Requires 10 or more paying customers.	$12 per person
Full-Day Trip. Group Rate. Requires 10 or more paying customers.	$20 per person
Half-Day Trip. Individuals.	$15 per person
Full-Day Trip. Individuals.	$25 per person
Overnight Trip. Individuals.	$45 per person
Short Trip. Clinchport to Copper Creek	$7.00 per person
False Cape: Day Kayak Paddle/Catered Lunch	$60 per person
False Cape: Back Bay by Water	$45 per person
Interpretive Kayak Tour, Solo Kayak: All parks where available unless otherwise noted.	$16 per person
Interpretive Kayak Tour, Solo Kayak: Natural Tunnel	
Settlers Run	$7.00 per person
Boones Run	$15 per person
Long Hunters Run	$25 per person
Interpretive Kayak Tour, Solo Kayak: Westmoreland, Caledon	$19 per person
Interpretive Kayak Tour, Solo Kayak: False Cape	$20 per person
Interpretive Kayak Tour, Tandem Kayak: All parks where available unless otherwise noted.	$22 per kayak
Interpretive Kayak Tour, Tandem Kayak: Westmoreland, Caledon	$25 per kayak
Tag-along Fee: Participant provides their own canoe or kayak. Not available at all sites.	$10 per person
Interpretive Stand-Up Paddle Board Tour: Westmoreland	$25 per person

Interpretive Pontoon Boat Tour: All parks where available.	$2.00 (Age 3 through 12) $3.00 (Age 13 and over)
Interpretive Tube Tour: all parks where available unless otherwise noted.	$6.00 per person
Lake Excursion and Ecology Tour	
Claytor Lake	$10 (Age 13 and over) $7.00 (Age 3 through 12)
Rental of Entire Boat (Exclusive Use): All parks where available	$60 per tour

Notes on Interpretive Canoe, Boat, and Paddleboat Programs:

1. Cancellation Policy for group reservations: Guest must cancel four days prior to the tour date in order to receive a refund. Any guest canceling less than four days before the start of the reservation will not be eligible for a refund. A one-time $10 cancellation fee will apply per reservation regardless of number of boats reserved. In the event of inclement weather where the park must cancel, the guest will be offered either a complete refund or reservation transfer to another date.

2. Additional costs for supplies and materials may apply.

4VAC5-36-150. Interpretive and educational tours and program fees.

INTERPRETIVE AND EDUCATIONAL TOURS AND PROGRAMS (NONTAXABLE)

Interpretive and Educational Tours and Programs		
PARK	PROGRAM	FEE
All parks unless otherwise noted:	Standard Interpretive Program or Tour: such as typical staff led nature hikes or campfire programs.	Free
	Fee-based Interpretive Program or Tour: (Fee only applies to programs or tours that have unusual costs or require special equipment, personnel, marketing, or other special arrangements).	$2.00 per person $6.00 per family
	Fee-based Night Hike or Evening Program or Evening Tour: (Fee only applies to programs or tours that have unusual costs or require special equipment, personnel, marketing, or other special arrangements).	$3.00 per person $8.00 per family
	Standard Workshop Fee	$5.00 per child (Age 12 and under) $15 per adult (Age 13 and over)
	Standard Wagon Ride Program	$3.00 per person $8.00 per family $25 exclusive group
	Extended or Special Event Wagon Ride Program	$4.00 per person $10 per family $75 exclusive group booking
	Park Outreach Program: Price per park staff member conducting program	$10 for under 2 hours $25 for 2 to 3 hours $50 for 4 hours plus
	Standard Junior Ranger Program: 4-day program. All parks unless noted below.	$10 full program $3.00 per day

	Haunted Hike	$1.00 (Age 3 through 12) $3.00 (Age 13 and over)
	Geo Caching or Orienteering Interpretive Program.	$3.00 per person $8.00 per family $25 per group
	Nature-Themed Birthday Party: Includes a nature talk, hike, games, songs, and time in the Nature Center for gifts and cakes. At least one staff member is present to conduct activities.	$96 per hour plus materials cost for 12 children $8.00 per additional child
	Standard Women's Wellness Weekend Program	$149 per person
Grayson Highlands	Junior Ranger Program	$5.00 per person per day
	Hayrides	$2.00 per child $3.00 per adult
	Adventure Rangers Interpretive Program	$10 per person per day
	Make a Birdhouse Program	$5.00 per person
	Make Your Own Hiking Stick Program	$3.00 per person
	2-Day Photography Class	$35 per person
Twin Lakes	Haunted Hike	$3.00 (Age 3 through 12) $5.00 (Age 13 and over)
Occoneechee, Caledon, Sky Meadows	Individual interpretive program pass: (Allows admission for one person to 4 interpretive programs valued at $3.00 or less)	$6.00 per pass
	Family interpretive program pass: (Allows admission for members of the same family to 4 interpretive programs valued at $8.00 or less)	$18 per pass
Pocahontas	Nature Camps	$100 per child per program plus materials cost $30 per child plus materials cost for Jr. Assistant. The Jr. Assistant helps the park staff in conducting camp programs.
	Curious Kids	$3.00 per program
	Nature and Discovery Programs (School/Groups Outreach)	$4.00 per child $80 minimum $15 additional if program is outside of Chesterfield County
Sky Meadows	Interpretive Program Series: 6-program series	$15 per person per program $45 per person per 4 programs $60 per person per 6 programs

	Nature and Discovery Programs (School/Groups Outreach)	$2.00 per child $50 minimum $15 additional if program is outside of the following counties: Fauquier, Frederick, Clark, and Loudoun
	~~House and Grounds Tour~~	~~$3.00 per person age 13 and older~~ ~~$2.00 per child age 6 through 12~~ ~~$8.00 per family~~
	Junior Ranger Outdoor Adventure Camp	$100 per child per program plus materials cost $30 per child plus materials cost for Jr. Assistant. The Jr. Assistant helps the park staff in conducting camp programs.
Smith Mountain Lake	Nature and Discovery Programs (School/Groups Outreach)	$10 per school visit
Southwest Virginia Museum	How Our Ancestors Lived	$5.00 per person
	Special Themed Interpretive Program	$10 per person
	Music or Literary Event	$5.00 per person
	Workshop (Adult)	$10 per person
	Workshop (Children)	$5.00 per person
	Nature and Discovery Programs (School/Groups Outreach)	$25 for under 2 hours $50 from 2 hours to under 4 hours $75 for 4 or more hours
	Guided Tour or Activity	School Groups: $1.50 per person Public Groups: $2.50 per person
	Step-On Tour Guide Service	$7.00 per person
Caledon	Caledon Eagle Tours	$6.00 per person $50 Flat Rate (minimum: 10; maximum: 20)
	All Group Programs up to 2 hours long	$5.00 per person
	Haunted Hay Ride	$5.00 per person (age 7 and over) Children under 7 free
	Special Program Bus Fee: Programs involving transportation within the natural area.	$3.00 per person
	Workshop (Adult)	$15 per person
	Workshop (Children)	$5.00 per person
Natural Tunnel: Cove Ridge	Guided Programs	$25 per program (Maximum 30 participants) $25 facility fee (If applicable)
	Environmental Education (Children's Activities)	$25 per program (Maximum 30 participants) $25 facility fee (If applicable)
	Environmental Education (Adult Facilitation)	$15 per person
Hungry Mother/ Hemlock Haven	Junior Naturalist Program	$4.00 per person per week $12 unlimited participation in interpretive season

Kiptopeke	Birding Program (Group Rates)	$35 (Corporate) $25 (Nonprofit)
York River	Guided Adventure Programs	$4.00 per person $40 per group (Minimum 12 persons)
Westmoreland	Guided Program Fee	$25 per person
Natural Tunnel	Junior Ranger Program (Includes T-Shirt)	$35 per person
	Wagon Ride Program	$50 Exclusive Education Group Booking
	Hay Wagon and Hot Dog Roast	$10 per person
	Bike Tours - 2 hours	$10 per person
	Extended Bike Tours - 4 hours	$15 per person
	Canoe and Bike Tour - 4 hours	$20 per person
	Halloween Haunted House/Hay Wagon Ride	$3.00 (Age 3 through 12) $5.00 (Age 13 and over)
Mason Neck	Junior Ranger Program	$50 per person
Holliday Lake	Field Archaeology Workshop	$25 per person
	Junior Ranger Program (3 half-day workshop) (Ages 6 to 13)	$25 per child
False Cape	Wildlife Watch Tour – Per Person	$8.00 per person
	Wilderness Survival Weekend (2-night stay)	$200 per person
	Wilderness Survival Weekend (1-night stay)	$100 per person
	Wilderness Survival Program	$16
	Astronomy Program	$16 per person
	Wild Women Weekend	$200 per person
	Summer Survival	$120 per person
	Blue Berry Blues	$20 per person
Staunton River	Interpretive Craft	$2.00 per person
First Landing	Junior Ranger Program 3 Hour Program 6 Hour Program	 $25 per person $50 per person
Bear Creek Lake	Junior Ranger Program	$20 per person
Leesylvania	Junior Ranger Program	$50 per person
	Halloween Haunted Hike	$2.00 per person $6.00 per group (4 person maximum)
	Interpretive Programs	$2.00 per person
	Kids Fishing Tournament	$2.00 per child
Natural Tunnel	Pannel Cave Tour	$10 per person $7.00 per person (Family-Group; 8-person minimum)

	Bolling Cave Tours	$15 per person $12 per person (Family-Group; 10-person minimum)
	Stock Creek Tunnel Tour/Snorkeling on the Clinch	$5.00 per person
New River Trail	New River Trail Seniors Van Tour Full Day	$25 per person
	New River Trail Seniors Van Tour Half Day	$15 per person
	Bertha Cave Tour	$10 per person
James River	Haunted Wagon Ride	$5.00 per person (Age 7 and over) Children 6 and under free
	Interpretive Archery Program	$5.00 per person
Belle Isle	Triple Treat Program: Hayride/Canoe/Campfire	$10 per person
	Junior Ranger 3-day program	$5.00 per class
	Bike Tour: visitors can supply their own bike or rent separately	$2.00 per person $6.00 per family

Notes on interpretive and educational tours and programs:

Additional costs for supplies and materials may apply.

4VAC5-36-160. Outdoor skill program fees.

OUTDOOR SKILL PROGRAMS (NONTAXABLE)

Outdoor Skill Programs		FEE
Grayson Highlands	Outdoor Survival Skills and Backpacking	$95 per person
	Basic Map and Compass	$25 per person
	Beginning Rock Climbing and Backpacking	$95 per person
	Advanced Map and Compass Skills	$25 per person
Westmoreland, Douthat, Hungry Mother, False Cape	Photography Workshop, with meals and lodging	$325 per person
	Photography Workshop, with meals, no lodging	$295 per person
	Photography Workshop, no meals, no lodging	$225 per person
	Nonparticipant Lodging and Food	$235 per person
	Nonparticipant Meals only	$125 per person
Lake Anna	Prospecting for Gold Workshop	$50 per person
Kipotopeke	Kayak Fishing Program	$35 per person
Hungry Mother	Mountain Empire Fly Fishing School	$225 per person
Grayson Highlands	Guided Fly Fishing Trip: Half-day Guided Fly Fishing Trip: Full-day	$50 per person $75 per person
Sky Meadows	~~Outdoor Skills Workshop~~	~~$5.00 per class per person~~ ~~$10 per class per family~~

~~Primitive Camping Series (3 classes = 1 series)~~	~~$15 per series per person $30 per series per family~~
~~Backpacking Series (4 classes = 1 series)~~	~~$20 per series per person $40 per series per family~~
Venture Realm Hiking Retreat	$53 per person

4VAC5-36-180. State park performing arts events fees.

STATE PARK PERFORMING ARTS EVENTS (NONTAXABLE)

State Parks Performing Arts Events:	FEE
All parks unless otherwise noted below:	Under age 3 is free $3.00 (Age 3 through 12) $5.00 (Age 13 and over)
Pocahontas Premier Shows	~~$8.00~~ $10 per person advance tickets, includes daily parking fee $10 per person day of show (does not include parking) Children ~~12~~ 10 and under free ~~$40~~ $45 per person season tickets-includes daily parking fee for day of all Premier shows $5.00 per person the day of show with coupon and the purchase of one ticket at full price
Natural Tunnel Gospel Singing Festival	$5.00 per vehicle
Douthat Performing Arts in the Park	Under age 3 is free $4.00 (Age 3 through 12) $9.00 (Age 13 and over)
Smith Mountain Lake: Music in the Park (per event)	Under age 12 is free $3.00 (Age 13 and over)
Pass for 10 events	$20
Pass for 15 events	$28

Note on Performing Arts Event Fees:

Cancellation Policy for Performing Arts Programs:

1. Generally, all events go on rain or shine and no refunds will be given. If an event is canceled by management, a full refund will be provided to ticket holders if rescheduling is not an option. No refunds will be given for any reason other than event cancellation.

2. "Ticket as Voucher" policy for Performing Arts Series: Generally, all events go on rain or shine. Should a specific event/program in the series be canceled by management, the cancellation policy regarding refunds (see 1 above) applies. However, unused tickets, including tickets not used due to purchaser's own decision, retain face value that may be applied to entry to subsequent events, including events in future seasons. No refunds will be given for any reason other than event cancellation.

4VAC5-36-190. Environmental education center fees.

ENVIRONMENTAL EDUCATION SERVICES AND FACILITIES FEES (TAXABLE unless otherwise noted)

PARK	SERVICE OR FACILITY	FEE
Caledon	Rental of Environmental Education Center	$60 per day $40 per half-day
First Landing	Chesapeake Bay Center Exhibit Area. Fee required after 5 p.m. or after regular operating hours	$25 per hour
False Cape State Park	Wash Woods Environmental Education Center - Use by educational group	$200 per night $60 day use
	Wash Woods Environmental Education Center - Use by noneducational group	$300 per night $100 day use
	Cancellation Fee	$50
	~~Deposit to accompany reservation application~~	~~$40~~
	Environmental Education Programs (Nontaxable)	$75
	Bus transportation for educational group (Nontaxable)	$36 round trip $18 one way
	Bus transportation for noneducational group (Nontaxable)	$48 round trip $24 one way
	Bus transportation within the park (Nontaxable)	$18 per hour
	Beach vehicle transportation for educational group (10 person minimum)	$100 round trip
	Beach vehicle transportation for noneducational group (10 person minimum)	$160 round trip
	Beach vehicle transportation, individual rate on regularly scheduled dates	$8.00 round trip per person
	Transportation, Additional Park Vehicle (Nontaxable)	$36 round trip
	Transportation for nonemergency but unplanned trips out of park:	
	Transportation for Camper	$18 per trip
	Transportation for Camper with Canoe or Kayak	$24 per trip
	Kayak/Canoe Trailer Transportation for Campers	$100 per trip
	After hours transportation surcharge	$8.00 per trip
	Equipment Rental	$25
Mason Neck	Mason Neck State Park Conference Room (Includes sampling and A.V. equipment)	$50 per half-day $80 per full-day
	Environmental Education Equipment only: Excludes conference room – outdoor activity only	$25 per half-day $40 per full-day
Leesylvania	Discovery Room	
	Teacher-Led Programs Up to 4 hours (Nontaxable)	$50
	Ranger-Led Programs Up to 4 hours (Nontaxable)	$85

Menu Programs: Picked by instructor – led by ranger; 1-hour 15-minute minimum (Nontaxable)	$30
Equipment Rental: For use outside of Visitor Center; 4 hour maximum	$20

Note on Environmental Education Center Fees:

Environmental Education Center Cancellation Policy: For day-use E.E.C. cancellation policy, Picnic Shelter cancellation policy shall apply. For overnight-use E.E.C. cancellation policy, cabin cancellation policy shall apply. Cancellation fees stipulated in these policies shall apply unless otherwise set out in this section.

4VAC5-36-200. Miscellaneous rental fees.

RENTALS (TAXABLE; Price here does not include tax)

Bike Rentals (includes helmet)	FEE
All parks where available unless otherwise noted	$3.00 per hour $8.00 per half-day $15 per full-day
New River Trail, James River, Mason Neck	$5.00 per hour $12 per half-day $18 per day
First Landing	$5.00 per hour $16 per day
Bike Helmet without bike rental	$1.00
Child Cart for bike	$5.00
Personal Bike Repair Services	$25 basic tune-up $60 standard tune-up $13.50 flat repairs $10 minor adjustments
Boat Rentals	
Standard Paddle Boat Rental:	
All parks where available unless otherwise noted	$4.00 per half-hour $6.00 per hour
Fairy Stone, Westmoreland, Hungry Mother	$5.00 per half-hour $8.00 per hour
Smith Mountain Lake	$25 per half-hour $35 per one hour
Standard Canoe Rental:	
All parks where available unless otherwise noted.	$8.00 per hour $15 per half-day $25 per full-day $40 for 24 hours $100 per week
Smith Mountain Lake	$8.00 per half-hour $12 per one hour $60 for 24 hours $30 additional for each day after first day

Claytor Lake	$12 per hour $35 per half-day $50 per day
Leesylvania, Mason Neck	$7.00 per half-hour $12 per hour $35 per half-day $50 per day
James River	$10 per hour (does not include shuttle) $40 per day (does not include shuttle) $120 per week (does not include shuttle)
Standard Float Trips:	
James River	
Bent Creek to Canoe Landing:	
Canoe	$45 Max 3 people
Single Kayak	$35 per kayak
Canoe Landing to Dixon Landing:	
Tubes	$12 per tube
Group of four or more	$10 per tube
Canoe	$15 per canoe
Single Kayak	$15 per kayak
Bent Creek to Dixon Landing:	
Canoe	$50 per canoe
Single Kayak	$40 per kayak
Shuttle Service Only:	
Canoe Landing to Dixon Landing, canoe or single kayak, scheduled or unscheduled	$2.00 per person $5.00 per canoe/kayak
Bent Creek Shuttle (Scheduled)	$5.00 per boat (canoe/kayak) $5.00 per person
Bent Creek Shuttle (Unscheduled)	$15 per boat (canoe/kayak) $15 per person
Tubes	$5.00 per person/Bent Creek Shuttle $2.00 between landings in park
Late Rental Fee	$15 per half hour past return time
New River Trail	$7.00 per hour $20 per half-day $30 per day $35 per half-day, includes canoe rental and shuttle $50 per full day, includes canoe rental and shuttle
Canoe Rental (includes shuttle)	

Trip A: Austinville to Foster Falls	$35 per canoe
Trip B: Ivanhoe to Austinville	~~$45~~ $50 per canoe
Trip C: Ivanhoe to Foster Falls	~~$50~~ $55 per canoe
~~Trip D: Foster Falls to Route 100~~	~~$45 per canoe~~
~~Trip E: Route 100 to Allisonia~~	~~$50 per canoe~~
Trip ~~F~~ D: Foster Falls to Allisonia	$55 per canoe
Kayak Rental (includes shuttle)	
Trip A: Austinville to Foster Falls	$25 per kayak
~~Trip B: Ivanhoe to Austinville~~	~~$35 per kayak~~
Trip ~~C~~ B: Ivanhoe to Foster Falls	$40 per kayak
~~Trip D: Foster Falls to Route 100~~	~~$35 per kayak~~
~~Trip E: Route 100 to Allisonia~~	~~$40 per kayak~~
Trip ~~F~~ C: Foster Falls to Allisonia	$45 per kayak
Standard Rowboat Rental, without motor:	
All parks where available unless otherwise noted	$6.00 per hour $12 per half-day $22 per full-day $36 per 24 hours $80 per week
Hungry Mother: Rowboats	$4.00 per hour $15 per day $40 per week
New River Trail: Rafts and flat-bottom boats	$7.00 per hour $20 per half-day $30 per day
Standard Rowboat Rental with electric motor and battery: All parks where available unless otherwise noted	$10 per hour $20 per 4 hours $36 per day $100 per 4 days $150 per week
Hungry Mother: Standard Rowboat Rental with electric motor and battery	$12 per hour $24 per 4 hours $45 per day $75 per 24 hours (limited to overnight guests)
Standard Motorboat Rental, 16-foot console steering, 25-45 horsepower outboard. All parks where available.	$18 per hour $90 per day
Standard Fishing Boat Rental with gasoline motor and one tank of fuel: All parks where available.	$10 per hour (2-hour minimum) $50 per day
Pedal Craft Rental: (Hydro-Bike, Surf-Bike, etc.) All parks where available unless otherwise noted.	
One person.	$8.00 per hour

Two person.	$10 per hour
Hungry Mother: Hydro Bike	$5.25 per half hour $8.00 per hour
Smith Mountain Lake: Hydro Bike	$8.00 per half hour $12 per hour $4.00 additional per hour after first hour $60 per 24 hours $30 additional per day after first day
Barracuda Boat. All parks where available	$10 per hour
Solo Kayak Rental:	
All parks where available unless otherwise noted	$8.00 per hour $20 per half-day $30 per day $40 for 24 hours $100 per week
Westmoreland	$9.00 per hour $17 per half-day $30 per day
Smith Mountain Lake	$8.00 per half hour $12 per hour $60 per 24 hours $30 additional per day after first day
Mason Neck	$6.00 per half-hour $10 per hour $35 per half-day $50 per day
James River	$7.00 per hour (does not include shuttle) $20 per day (does not include shuttle) $80 per week (does not include shuttle) $12 per half hour past return time
Claytor Lake	$10 per hour $25 per half-day $40 per day
Tandem Kayak Rental:	
All parks where available unless otherwise noted.	$10 per hour $20 per half-day $30 per full-day $45 for 24 hours $120 per week
Westmoreland	$12 per hour $22 per half-day $36 per day
Smith Mountain Lake	$10 per half-hour $15 per hour $80 for 24 hours $30 additional for each day after first day

Mason Neck	$8.00 per half-hour $15 per hour $45 per 4 hours $60 per day
Smith Mountain Lake: 14-foot fishing boat with 5 hp (3 person capacity). Rental does not include fuel and oil. Damage deposit of $200 required.	$50 for 3 hours $10 additional per hour after first 3 hours $150 for 24 hours $30 additional per day after first day
Claytor Lake: 16-foot Bass Tracker with 60 hp motor. Damage deposit of 50% required.	$30 per hour $75 per half-day $115 per day
~~Claytor Lake: 17-foot bowrider with 135 hp motor. Damage deposit of 50% required~~	~~$45 per hour~~ ~~$120 per half-day~~ ~~$185 per day~~
Claytor Lake: 20-foot pontoon boat with 90 hp motor. Damage deposit of 50% required.	$45 per hour $120 per half-day $185 per day
Claytor Lake: 21-foot pontoon boat (10 person capacity) with 75 hp motor and tow hook. Damage deposit of 50% required.	$45 per hour $125 per half-day $195 per day
Claytor Lake: 24-foot pontoon boat with 75 hp motor. Damage deposit of 50% required.	$50 per hour $140 per half-day $210 per day
Claytor Lake: 24-foot pontoon boat with 115 hp motor. Damage deposit of 50% required.	$55 per hour $150 per half-day $225 per day
Claytor Lake: 30-foot pontoon boat with 115 hp motor. Damage deposit of 50% required.	$60 per hour $165 per half-day $250 per day
Claytor Lake: 18-foot bowrider with 190 hp motor. Damage deposit of 50% required.	$50 per hour $135 per half-day $205 per day
Claytor Lake: 19-foot bowrider with 220 hp motor, Damage deposit of 50% required.	$55 per hour $150 per half-day $225 per day
Occoneechee: 17-1/2-foot fishing boat. Rental includes 30 gallons of fuel. Damage deposit of $200 required.	$85 per hour $20 additional per hour after first hour $175 per 8 hours $875 per 7 day week
Occoneechee: 20-foot pontoon boat with motor (8 person capacity) Rental includes 30 gallons of fuel. Damage deposit of $200 required.	$85 per hour $20 additional per hour after first hour $175 per 8 hours $875 per 7 day week

Occoneechee: 22-foot pontoon boat with motor (10 person capacity) Rental includes 30 gallons of fuel. Damage deposit of $200 required.	$95 per hour $20 additional per hour after first hour $185 per 8 hours $925 per 7 day week
Occoneechee: 25-foot pontoon boat with motor (14 person capacity) Rental includes 30 gallons of fuel. Damage deposit of $200 required.	$110 per hour $25 additional per hour after first hour $230 per 8 hours $1,150 per 7 day week
Smith Mountain Lake: 18-20-foot Runabout with 190 hp (8 person capacity). Rental does not include fuel and oil. Damage deposit of $200 required.	$165 for 3 hours $20 additional per hour after first 3 hours $255 per 8 hours $320 for 24 hours $100 additional per day after first day
~~Claytor Lake: 18-foot pontoon boat (7 person capacity) or 21-foot pontoon boat (9 person capacity). Damage deposit of 50% required~~	~~$40 per hour~~ ~~$110 per half-day~~ ~~$170 per day~~
Claytor Lake: Jet Ski/Personal Watercraft	~~$60~~ $50 per hour ~~$150~~ $140 per 4 hours ~~$225~~ $210 per 8 hours
Smith Mountain Lake: 24-foot pontoon boat with 40 hp (10-12 person capacity). Damage deposit of $200 required.	$90 for 3 hours $20 additional per hour after first 3 hours $165 per 8 hours $215 for 24 hours $80 additional each day after first day
Smith Mountain Lake: Personal Watercraft (Waverunner 700). Rental does not include fuel and oil. Damage deposit of $500 required.	$180 for 3 hours $20 additional per hour after first 3 hours $270 per 8 hours $335 for 24 hours $130 additional per day after first day
Belle Isle: Motorboat less than 25 horsepower (3 gallons of fuel included, 2 hour minimum)	$15 per hour $60 per half-day $100 per day
Belle Isle: Motorboat 25-49 horsepower (11 gallons of fuel included, 2 hour minimum)	$22 per hour $70 per half-day $110 per day
Standard Damage/Replacement Fees: All parks where available unless otherwise noted. Not required for damage due to normal wear and tear.	
Paddle	$20
Anchor/Rope	$40
Fuel Tank/Hose	$60
Fire Extinguisher	$25
Throw Cushion	$10
Propeller (small)	$100
Propeller (large)	$135

Personal Flotation Device (PFD): replacement fee for lost/damaged PFD	$25 each
Other Rentals:	
Personal Flotation Device (PFD): When separate from boat rental.	$1.00 per day
Smith Mountain Lake, James River: Personal Floatation Device, type II.	$5.00 for first day $1.00 additional days
Smith Mountain Lake: Personal Floatation Device, type III	$7.00 for first day $2.00 additional days
Canoe/Kayak Paddles: All parks where available unless otherwise noted.	$5.00 per day
New River Trail: Float Tubes	$5.00 per hour $12 per half-day $18 per day
James River:	
Cooler Tubes	$3.00 per day
Tubes	$8.00 per hour (does not include shuttle) $20 per day (does not include shuttle) $12 per half hour past return time
Claytor Lake: 2-person tow tube and towrope (with rental of boat only)	$20 per 2 hours $25 per half-day $30 per day
Claytor Lake: Water skis and towrope (with rental of boat only)	$20 per 2 hours $25 per half-day $30 per day
Claytor Lake: Kneeboard and towrope (with rental of boat only)	$15 per 2 hours $20 per half-day $25 per day
Smith Mountain Lake: Tow tube; Water Skis; Knee Board	$15 per day with boat rental $5.00 per additional day $25 per day without boat rental
Smith Mountain Lake: Wake Board	$25 per day with boat rental $10 per additional day $30 per day without boat rental
Mobile Pig Cooker: All parks where available unless otherwise noted.	$40 per day
GPS Units	$6.00 per unit per half-day $10 per unit per day
Volleyball Net and Ball Rental: All parks where available.	$10
Binocular Rentals (2 hours): All parks where available.	$2.00
Beach Floats: All parks where available.	$1.00 per hour $3.00 for 4-hours $5.00 for full-day

Surf Lounge Floating Chair Rental. All parks where available.	$2.00 per hour, single chair $5.00 per half-day, single chair $7.00 per full day, single chair $3.00 per hour, double chair $7.00 per half-day, double chair $10 per full day, double chair
Body Board: First Landing	$6.00 per day
Standard Stand-Up Paddle Board: Westmoreland	$15 per hour
Beach Umbrella: All parks where available unless otherwise noted.	$3.00 per hour $8.00 for 4 hours $15 for full-day
First Landing	$6.00 per day
Beach Chair: All parks where available	$5.00 per day
First Landing	$6.00 per day
Fishing Rods: All parks where available unless otherwise noted.	$5.00 per half-day
First Landing	$6.00 per day $3.00 per rod per fishing program
Tents with a group camp reservation. All parks where available.	
2-person tent	$12 per day
3-person tent	$20 per day
4-person tent	$25 per day
5-person tent	$30 per day
Coleman Camp Stove Rental, includes fuel	$10 per day
Tabletop Propane Grill, includes fuel	$15 per day
Coin-Operated Washing Machine: All parks where available unless otherwise noted.	$1.25 per load, tax included
First Landing	$1.50 per load, tax included
Coin Operated Dryer: All parks where available unless otherwise noted.	$1.25 per load, tax included
First Landing	$1.50 per load, tax included
Pump Out: All parks where available unless otherwise noted.	$5.00
Horse Rentals:	
All parks where available unless otherwise noted.	$20 per one-hour ride ~~$40~~ $35 per two-hour ride $100 per full day ride
Pony Rides: All parks where available unless otherwise noted.	$5.00 per 15 minutes
Horseback Riding Lessons: All parks where available unless otherwise noted.	$25 per lesson on group basis $30 per lesson for individual
Horseback Summer Day Camp: All parks where available unless otherwise noted.	$180 per person per week

Horseshoe or Croquet Rental for Campers. All parks where available.	$1.00 per hour $5.00 per day $20 deposit

VA.R. Doc. No. R13-3444; Filed October 31, 2012, 9:07 a.m.

DEPARTMENT OF MINES, MINERALS AND ENERGY

Notice of Suspension of Effective Date

Title of Regulation: **4VAC25-150. Virginia Gas and Oil Regulation (amending 4VAC25-150-10, 4VAC25-150-60, 4VAC25-150-80, 4VAC25-150-90, 4VAC25-150-100, 4VAC25-150-110, 4VAC25-150-120, 4VAC25-150-135, 4VAC25-150-140, 4VAC25-150-150, 4VAC25-150-160, 4VAC25-150-180, 4VAC25-150-190, 4VAC25-150-200, 4VAC25-150-210, 4VAC25-150-220, 4VAC25-150-230, 4VAC25-150-240, 4VAC25-150-250, 4VAC25-150-260, 4VAC25-150-280, 4VAC25-150-300, 4VAC25-150-310, 4VAC25-150-340, 4VAC25-150-360, 4VAC25-150-380, 4VAC25-150-390, 4VAC25-150-420, 4VAC25-150-460, 4VAC25-150-490, 4VAC25-150-500, 4VAC25-150-510, 4VAC25-150-520, 4VAC25-150-530, 4VAC25-150-550, 4VAC25-150-560, 4VAC25-150-590, 4VAC25-150-600, 4VAC25-150-610, 4VAC25-150-620, 4VAC25-150-630, 4VAC25-150-650, 4VAC25-150-660, 4VAC25-150-670, 4VAC25-150-680, 4VAC25-150-690, 4VAC25-150-700, 4VAC25-150-711, 4VAC25-150-720, 4VAC25-150-730, 4VAC25-150-740, 4VAC25-150-750).**

Statutory Authority: §§ 45.1-161.3 and 45.1-361.27 of the Code of Virginia.

In accordance with § 2.2-4015 A 4 of the Code of Virginia, the Department of Mines, Minerals and Energy has elected to suspend the Virginia Gas and Oil Regulation, 4VAC25-150, as published in 29:3 VA.R. 355-380 October 8, 2012, finding it necessary and appropriate to do so. Unless withdrawn by the department, a revised regulation will be published in the Virginia Register of Regulations at a later date with an effective date no earlier than 15 days from publication of the readoption action. During that 15-day period, if the department receives requests from at least 25 persons for the opportunity to comment on new substantial changes, the department shall suspend the regulation pursuant to § 2.2-4007.06 of the Code of Virginia.

Agency Contact: Michael Skiffington, Regulatory Coordinator, Department of Mines, Minerals and Energy, 1100 Bank Street, 8th Floor, Richmond, VA 23219-3402, telephone (804) 692-3212, FAX (804) 692-3237, TTY (800) 828-1120, or email mike.skiffington@dmme.virginia.gov.

VA.R. Doc. No. R08-1318; Filed November 2, 2012, 9:15 a.m.

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TITLE 8. EDUCATION

STATE BOARD OF EDUCATION

Final Regulation

Title of Regulation: **8VAC20-120. Career and Technical Education Regulations (amending 8VAC20-120-10 through 8VAC20-120-50, 8VAC20-120-70, 8VAC20-120-80, 8VAC20-120-100 through 8VAC20-120-170).**

Statutory Authority: §§ 22.1-16 and 22.1-227 of the Code of Virginia.

Effective Date: December 19, 2012.

Agency Contact: Anne Rowe, CTE Coordinator, Department of Education, P.O. Box 2120, Richmond, VA 23218, telephone (804) 225-2838, FAX (804) 371-2456, or email anne.rowe@doe.virginia.gov.

Summary:

The Board of Education made several updates to include regulations from other regulatory documents that previously had not been included, add and amend definitions to reflect current state and federal terminology, and clarify current policy. The clarifications of current policy include but are not limited to: (i) specifying the federal Carl D. Perkins Career and Technical Education Act of 2006 (Perkins Act) requirements that no less than 60% of federal funds may be expended on required expenditures and up to 40% may be spent on permissive uses, (ii) clarifying that local school divisions can ask for approval on items not listed on the recommended equipment lists maintained by the Department of Education, (iii) modifying language to allow the possibility for a change in the frequency of plan submission, (iv) adding language referring to the 2006 Perkins grant and 2009 Standards of Accreditation career plans, (v) amending the section concerning maximum class size for greater clarity, (vi) clarifying that categorical funding is available to students who take industry credentials approved by the board, (vii) specifying reporting requirements, and (viii) adding a reference for alignment with Standards of Accreditation requirements. Further, the board will allow localities to fund equipment on a maintenance of effort basis as opposed to the current requirement of a local match equal to the amount of state funding for career and technical education equipment.

The changes to the proposed regulations include a name change of a career and technical student organization that changed at the national level. When making that change in

the definitions, all acronyms and full names were added to the identification of the organizations.

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 120
REGULATIONS GOVERNING CAREER AND TECHNICAL EDUCATION ~~REGULATIONS~~]

Part I
General Provisions

8VAC20-120-10. Authority to promulgate; requirements for compliance with state and federal regulations.

These regulations are promulgated by the Board of Education pursuant to ~~§ 22.1 216~~ § 22.1-16 of the Code of Virginia for career and technical education programs funded in whole or in part with state funds. Federal laws pertaining to such programs permit state regulations in addition to federal requirements (see Carl D. Perkins ~~Vocational and Technical Education~~ Act of ~~1998,~~ 2006 (Perkins Act of 2006), § 121 (20 USC § 2341)).

Local education agencies operating career and technical education programs shall comply with these regulations of the Board of Education and requirements of applicable federal legislation, including the Education Department General Administrative Regulations (EDGAR) (34 CFR [~~Part~~] 74.2) and the ~~Carl D.~~ Perkins ~~Vocational and Technical Education~~ Act of ~~1998~~ 2006.

8VAC20-120-20. Definitions.

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

"Academic and career plan" means the student's program of study for high school graduation and postsecondary career pathway based on the student's academic and career interests. The academic and career plan shall be developed in accordance with guidelines established by the Board of Education. (Also see the definition of "program of study.")

"All aspects of an industry" ~~includes, with respect to a particular industry that a student is preparing to enter: planning, management, finances, technical and production skills, underlying principles of technology, labor and environmental issues related to that industry~~ means strong experience in, and comprehensive understanding of, the industry that the individual is preparing to enter.

"Board" means [that] the ~~Virginia~~ Board of Education [~~, that~~] is designated as the State Board for Career and Technical Education to carry out the provisions of the federal Perkins Act of 2006 and any new amendments or acts, and as such shall promote and administer the provisions of agricultural education, business and information technology, marketing, family and consumer sciences, health and medical services, technology education, [and] trade [,] and industrial education in the public middle and high schools, regional schools established pursuant to § 22.1-26 of the Code of Virginia, postsecondary institutions, and other eligible institutions for youth and adults.

"Career clusters and pathways" means a grouping of occupations and industries based on commonalities. Sixteen career clusters provide an organizing tool for schools, small learning communities, academies, and magnet schools. Within each career cluster, there are multiple career pathways that represent a common set of skills and knowledge, both academic and technical, necessary to pursue a full range of career opportunities within that pathway, ranging from entry level to management and including technical and professional career specialties. Based on the skills sets taught, all CTE courses are aligned with one or more career clusters and career pathways. The states' career clusters refers to a clearinghouse for career clusters research, products, services and technical assistance for implementation of the states' career cluster framework for lifelong learning.

"Career and technical student ~~organizations~~ organization" means ~~those organizations~~ an organization for individuals enrolled in a career and technical education ~~programs~~ program that ~~engage~~ engages in ~~an annual program of work including~~ career and technical activities ~~that are~~ as an integral part of the instructional program. These organizations may have state and national units that aggregate the work and purposes of instruction in career and technical education at the local level; if so, these organizations shall be (i) National FFA Organization [, formerly known as Future Farmers of America]; (ii) Future Business Leaders of America [(FBLA)]; (iii) Future Educators Association [(FEA)]; (iv) Health Occupations Students of America [(HOSA)]; ~~(iv)~~ (v) Family, Career and Community Leaders of America [(FCCLA)]; ~~(v)~~ (vi) [DECA, formerly known as] DECA: An Association of Marketing Students; ~~(vi)~~ (vii) Technology Student Association [(TSA)]; ~~and (vii)~~ (viii) Skills [~~USA VICA~~ USA]; and (ix) other student organizations that may be approved at the state and national levels.

"Categorical entitlement" means the amount of funding a local education agency is eligible to receive for a specific purpose, subject to state or federal regulations and the availability of funds.

"Competency-based education" means ~~an instructional system that focuses on competencies needed for specific jobs, evaluation~~ [~~applied~~ relevant] learning that contributes to the academic knowledge, higher-order reasoning and problem-solving skills, work attitudes, [~~general~~] workplace readiness skills, technical skills, and occupation-specific skills, and knowledge of all aspects of an industry, including entrepreneurship, of an individual. Evaluation of student progress is based on standards of the occupation or field~~,~~ and the maintenance of student records of achievement in skill development.

"Cooperative education" means a method of ~~instruction that combines career and technical classroom instruction with paid employment directly related to the classroom instruction. Both student instruction and employment are planned and supervised by the school and the employer so that each contributes to the student's career objectives and employability.~~ education for individuals who, through written cooperative arrangements between a school and employers, receive instruction, including required rigorous and challenging academic courses and related career and technical education instruction, by alternation of study in school with paid employment in any occupation field, which alternation (i) shall be planned and supervised by the school and employer so that each contributes to the education, employability, and career objective of the individual; and (ii) may include an arrangement in which work periods and school attendance may be on alternate half days, full days, weeks, or other periods of time in fulfilling the cooperative program.

"Data" means information, both written and verbal, concerning career and technical education programs, activities, and students. Data include financial, administrative, demographic, student performance, and programmatic information and statistics.

"Department" means the Virginia Department of Education.

~~"Disadvantaged" means individuals (other than individuals with disabilities) who have economic or academic disadvantages and who require special services and assistance to enable them to succeed in career and technical education programs. Such term includes individuals who are members of economically disadvantaged families, migrants, and individuals who are dropouts from or who are identified as potential dropouts from secondary schools.~~

"Disability" means, with respect to an individual (i) a physical or mental impairment that substantially limits one or more of the major life activities of such individual; (ii) a record of such impairment; or (iii) being regarded as having such an impairment.

"Displaced homemaker" means an individual who (i) has worked primarily without remuneration to care for a home and family, and for that reason has diminished marketable skills; has been dependent on the income of another family member but is no longer supported by that income; or is a parent whose youngest dependent child will become ineligible to receive assistance under [~~part~~ Part] A of [~~title~~ Title] IV of the Social Security Act (42 USC § 601 et seq.) not later than two years after the date on which the parent applies for assistance under such title; and (ii) is unemployed or underemployed and is experiencing difficulty in obtaining or upgrading employment.

~~"Employability skills" means the generic skills related to seeking, obtaining, keeping and advancing in an occupation.~~

"Entitlement" means the amount of funding a local education agency is eligible to receive, subject to state or federal regulations and the availability of funds.

"Equipment" means ~~any instrument, machine, apparatus, or set of articles which meets all of the following criteria:~~ tangible nonexpendable personal property including exempt property charged directly to the award having a useful life of more than one year.

~~1. It retains its original shape, appearance, and character with use;~~

~~2. It does not lose its identity through fabrication or incorporation into a different or more complex unit or substance;~~

~~3. It is nonexpendable;~~

~~4. Under normal use, it can be expected to serve its principal purpose for at least one year; and~~

~~5. Excludes supplies and materials as defined by the Virginia Department of Planning and Budget's Expenditure Structure, May 2001.~~

"Extended contract" means a period of time provided to instructors for employment beyond the regular contractual period.

"Federal program monitoring" means monitoring and evaluation program effectiveness and ensuring compliance with all applicable state and federal laws.

"Follow-up survey" means the collection of information regarding the status of students following completion of a career and technical education program.

"Individualized education program" or "IEP" means a written statement for a child with a disability that is developed, reviewed, and revised in a team meeting in accordance with this chapter. The IEP specifies the individual educational needs of the child and what special education and related services are necessary to meet the child's educational needs (34 CFR 300.22).

"Individual with limited English proficiency" means a secondary school student, an adult, or an out-of-school youth who has limited ability in speaking, reading, writing, or understanding the English language and (i) whose native language is a language other than English and (ii) who lives in a family or community environment in which a language other than English is the dominant language.

"Industry credential" means the successful completion of an industry certification examination or an occupational competency assessment in a career and technical education field that confers certification of skills and knowledge from a recognized industry or trade or professional association or the acquiring of a professional license in a career and technical education field from the Commonwealth of Virginia. The certification examination or occupational competency assessment used to verify student achievement must be approved by the Board of Education.

"Local career and technical education plan" means a document submitted by a local education agency as prescribed by the Board of Education ~~setting forth proposed career and technical education programs, services, activities, and specific assurances of compliance with federal regulations~~ describing how the career and technical education programs required for funding will be maintained and how career and technical education activities will be carried out with respect to meeting state and local adjusted levels of performance established under Perkins Act of 2006, Accountability, § 113 (20 USC § 2323).

"Local education agency" means ~~the local school division responsible for providing educational services to students; a board of education or other legally constituted local school authority having administrative control and direction of public elementary or secondary schools in a city, county, town, school division, or political subdivision in a state, or any other public educational institution or agency having administrative control and direction of a career and technical education program~~ a public board of education or other public authority legally constituted within a state for either administrative control or direction of, or to perform a service function for, public elementary schools or secondary schools in a city, county, township, school district, or other political subdivision of a state, [or for a combination of school divisions or counties that is recognized] in a state as an administrative agency for its public elementary schools or secondary schools.

"Maintenance of effort" means the assurance that localities continue to provide funding for career and technical education (CTE) programs at least at the level of support of the previous year.

"Nontraditional fields" means occupations or fields of work, including careers in computer science, technology, and other current and emerging high skill occupations, for which individuals from one gender comprise less than 25% of the individuals employed in each such occupation or field of work.

"Performance measures" means core indicators of performance for careers and technical education students at the secondary level that are valid and reliable and that include measures identified in the [~~Accountability~~ accountability] section of the Perkins Act of 2006 (20 USC § 2323).

"Program of study" or "plan of study" means planning a sequence of academic, career and technical, or other elective courses that (i) incorporate secondary education and postsecondary [education] elements; (ii) include coherent and rigorous content aligned with challenging academic standards and relevant career and technical content in a coordinated, nonduplicative progression of courses that align secondary education with postsecondary education to adequately prepare students to succeed in postsecondary education; (iii) may include opportunity for secondary students to participate in dual or concurrent enrollment programs or other ways to acquire postsecondary education credits; and (iv) lead to an industry-recognized credential, license, or certificate or an associate degree at the secondary or postsecondary level or a baccalaureate or higher degree at the postsecondary level. (Also see the definition of "academic and career plan.")

"Section 504" means that section of the Rehabilitation Act of 1973 (29 USC § 791 et seq.), as amended, that is designed to eliminate discrimination on the basis of a disability in any program or activity receiving federal financial assistance.

"Special populations" means (i) individuals with disabilities; (ii) individuals from economically disadvantages families, including foster children; (iii) individuals preparing for nontraditional fields; (iv) single parents, including single pregnant women; (v) displaced homemakers; or (vi) individuals with limited English proficiency.

"Training agreement" means a ~~formal document, signed by the instructor, employer, parent or guardian, student, and school administrator, which states the requirements affecting the cooperative education student, the terms of the student's employment, and the responsibilities of all parties involved~~ written statement of commitment from the student, the parent, the training station, and the teacher-coordinator. It is a required formal document that spells out the responsibilities of all involved parties in the cooperative education method of instruction.

"Training plan" means a required formal document that identifies classroom and on-the-job instruction ~~which~~ that contributes to the employability [and on-going development] of each cooperative education student. (A recommended format is available from the Department of Education.)

"Work station" means an area in a classroom/laboratory that includes the necessary environment, instructional and consumable materials, and equipment to enable each student to accomplish competencies within a career and technical education course.

"Workplace readiness skills" means a list of personal qualities and people skills, professional knowledge and skills, and technology knowledge and skills identified by Virginia employers that are essential for individual workplace success and critical to Virginia's economic competitiveness. These skills will be updated as required.

"Verified unit of credit" or "verified credit" means credit awarded for a course in which a student earns a standard unit of credit and achieves a passing score on a corresponding end-of-course Standards of Learning (SOL) test or an additional test approved by the Board of Education as part of the Virginia assessment program.

Part II

Administration of Career and Technical Education Programs

8VAC20-120-30. State/federal financial assistance.

Financial assistance shall be provided to support the operation, improvement, and expansion of career and technical education.

1. Financial assistance provided through entitlements resulting from full-time equivalent student enrollments shall be used to support career and technical education program operation.

2. Financial assistance provided through categorical entitlements shall be used to support the following:

a. Principals and assistant principals of technical education centers if at least 50% of their time is spent in career and technical education program administration or supervision;

b. Extended contracts of instructors for activities related to the coordination, development, or improvement of career and technical education programs;

c. Equipment included on the Recommended Equipment Approved for Career and Technical Education Programs lists by the Department of Education or local option approved by the Department of Education; ~~and~~

d. Adult occupational career and technical education to provide opportunities for adults to prepare for initial employment, retraining, or career advancement~~.~~; and

e. Funding for industry credentials appearing on the Virginia Board of Education approved list.

3. No less than 60% of federal funds may be expended on required expenditures and up to 40% may be spent on permissive uses of funds as identified in the Perkins Act of 2006. If a school division does not meet the Perkins Act of 2006 performance measures, then the department may direct local expenditures toward uses of funds to improve the division's performance.

8VAC20-120-40. Local career and technical education plan.

Each eligible participant shall submit to the Department of Education a local career and technical education plan for review and approval. The local plan will be submitted as specified in federal legislation. ~~In addition to the local career and technical education plan, an~~ An annual budget funding application ~~will~~ shall be submitted to the department for review and approval.

8VAC20-120-50. Career and Technical Education Advisory [~~Council~~ Committee].

Each local education agency or region shall establish a general career and technical education advisory [~~council~~ committee] to provide recommendations to the local educational agency (or board) on current job needs and the relevancy of career and technical education programs offered and to assist in the development, implementation, and evaluation of the local plan and application.

1. [~~Councils~~ Committees] shall be composed of members of the public, including students, teachers, parents, and representatives from business, industry, and labor, with appropriate representation of both sexes and racial and ethnic ~~minorities~~ groups found in the school, community, or region served by the [~~council~~ committee].

2. The [~~council~~ committee] shall meet at regular intervals during the year to assist in the planning, implementing, and assessing of career and technical education programs.

8VAC20-120-70. Reporting requirements.

Local education agencies shall provide data on career and technical education for federal and state accountability requirements, planning, and evaluation as prescribed by federal legislation and the Department of Education.

Local education agencies [(LEAs)] shall participate in the federal program monitoring as prescribed by the Department of Education and as required by the Perkins Act of 2006.

8VAC20-120-80. Management of equipment inventory.

Local education agencies shall maintain a current inventory of all equipment items purchased in whole or in part with federal or state funds. Equipment purchased with state funds must:

1. Be acquired in accordance with state procurement laws and regulations;

2. Include ~~a~~ local ~~match equal to the amount of state~~ funding that would provide maintenance of effort; and

3. Be ~~listed~~ itemized on the Recommended Equipment Approved for Career and Technical Education Programs list provided by the ~~department~~ Department of Education or local option approved by the Department of Education.

Equipment purchased with combined state and federal funds must be used in accordance with provisions of the Carl D. Perkins ~~Vocational~~ Career and Technical Education Act of ~~1998~~ 2006, and acquired and disposed of in accordance with federal Education Department General Administrative Regulations (EDGAR) and appropriate state procurement laws and regulations.

Part III

Operation of Career and Technical Education Programs

8VAC20-120-100. Access to career and technical education programs.

Career and technical education programs administered by local education agencies receiving federal or state education funds shall be made equally available and accessible to all persons~~, regardless~~ [and] specifically prohibits discrimination on the basis of sex, race, ~~creed, age~~ [~~,~~] color, ~~disability, or~~ national origin [,] religion, age, political affiliation, or veteran status, or against otherwise qualified persons with disabilities.

8VAC20-120-110. New career and technical education programs.

The need for new ~~occupational~~ career and technical preparation programs shall be based on student interests and labor market ~~demands~~ needs.

8VAC20-120-120. Program requirements.

A. Career and technical education programs shall be competency based and meet the following criteria:

1. Career and technical education programs are aligned with states' career clusters and career pathways that allow for utilization with academic and career plans;

2. State-established, industry-validated competencies are identified and stated;

~~2.~~ 3. Competencies are specified to students prior to instruction;

~~3.~~ 4. Measures for successful performance of individual competencies are identified, stated, and used to evaluate achievement of competencies;

~~4.~~ 5. A system exists for rating and documenting the competency performance of each student; and

~~5.~~ 6. Competencies shall address all aspects of ~~the~~ an industry and ~~employability~~ workplace readiness skills.

B. Performance measures, as determined by the Department of Education, will be achieved annually.

C. Career and technical education programs must be provided in middle and secondary schools. The middle school must include a minimum of one career and technical offering. Each secondary school shall provide a minimum of three career and technical program areas to include a minimum of 11 course offerings.

D. Career and technical education programs must provide industry credentialing, certification, and licensure as approved by the Board of Education to meet requirements for verified credit.

8VAC20-120-130. Individualized programs for students with disabilities.

Essential competency profiles provided by the Department of Education for career and technical education courses may be modified for students with Individualized Education Programs ~~(IEP's)~~ (IEPs) or Section 504 Plans who are enrolled in career and technical education courses. Such modification shall be made in conformance with IEP requirements as stated in Regulations Governing Special Education Programs for Children with Disabilities in Virginia (8VAC20-81). The modified list of essential competencies must, as a group, be selected so that student attainment of the essential competencies prepares the student for a job or ~~occupation~~ career.

8VAC20-120-140. Cooperative education.

~~A~~ Career and technical education programs using the cooperative education method of instruction shall:

1. Develop and follow a training plan and training agreement ~~shall be developed and followed~~ for each student receiving training through cooperative education. ~~1. Career and technical education programs using the cooperative education method of instruction shall:~~

~~a. Be limited to an average of 20 students per instructor per class period with no class being more than 24 where the cooperative education method of instruction is required;~~

~~b. Have a class period assigned to the instructor for on-the-job coordination for each 20 students participating in on-the-job training; and~~

~~c. Specify provisions for instructor travel for on-the-job coordination. 2.~~ Parties to the training agreement shall include the student, parent or guardian, instructor, employer, and a school administrator [~~.~~; and]

2. Specify provisions for instructor travel for on-the-job coordination.

8VAC20-120-150. Maximum class size.

Enrollments in career and technical education courses shall not exceed the number of individual work stations.

1. Career and technical education laboratory classes that use equipment that has been identified by the U.S. Department of Labor for hazardous occupations shall be limited to a maximum of 20 students per laboratory. The career and technical education courses that have this restriction are published annually by the Virginia Department of Education.

2. Career and technical education courses designed specifically and approved for students who are disadvantaged shall be limited to an average of 15 students per instructor per class period with no class being more than 18.

3. Career and technical education courses designed specifically and approved for students with disabilities shall be limited to an average of 10 students per instructor per class period with no class being more than 12 or up to an average of 12 students per class period with no class being more than 15 where an instructional aide is provided.

4. Career and technical education programs offering classes that require the cooperative education method of instruction shall:

a. Be limited to an average of 20 students per instructor per class period with no class being more than 24; and

b. Have a class period assigned to the instructor for on-the-job coordination for each 20 students participating in the on-the-job training.

8VAC20-120-160. Career and technical education student organizations.

A. All career and technical education students shall be provided opportunities to participate in instructional activities of the local organization.

B. A career and technical education student ~~organizations~~ organization shall be an integral and active part of each secondary career and technical program (grades 9, 10, 11, 12) offered.

C. Each middle school career and technical education program (grades 6, 7, 8) offered shall include co-curricular instructional activities related to the respective career and technical education student organization.

D. Where dues are collected for membership in such organizations, payment of such dues shall not determine a student's participation in instructional activities of the local organization.

8VAC20-120-170. Student safety.

A. Each career and technical education program shall include health and safety standards, including protective eye devices, that are applicable to the operation of that program, ~~which~~ that shall be made an integral part of program instruction.

B. Each career and technical education program shall comply with applicable federal and state laws and regulations related to health and safety.

DOCUMENTS INCORPORATED BY REFERENCE (8VAC20-120)

~~Expenditure Structure, May 2001, Department of Planning and Budget.~~

Guidelines for Academic and Career Plans, Virginia Department of Education, September 17, 2009.

VA.R. Doc. No. R10-2244; Filed October 9, 2012, 12:25 p.m.

Final Regulation

Titles of Regulations: **8VAC20-370. Rules Governing Fees and Charges (repealing 8VAC20-370-10).**

8VAC20-720. Regulations Governing Local School Boards and School Divisions (adding 8VAC20-720-80).

Statutory Authority: § 22.1-16 of the Code of Virginia.

Effective Date: December 19, 2012.

Agency Contact: Melissa Luchau, Office of Policy & Communications, Department of Education, P.O. Box 2120, 101 North 14th Street, 25th Floor, Richmond, VA 23219, telephone (804) 225-2924, FAX (804) 225-2524, or email melissa.luchau@doe.virginia.gov.

Summary:

This action repeals current regulations governing fees charged by local school divisions and creates new provisions.

In addition to a different location within the Virginia Administrative Code, the regulations governing fees charged by local school divisions have the following changes: (i) local school boards that charge fees are required to have a policy and a fee schedule to provide to parents annually and to post on the school division's website; (ii) the policy will include a provision to waive or reduce fees for economically disadvantaged students and students whose families are undergoing economic hardships; (iii) the policy and fee schedule is required to be consistent across the school division; and (iv) no fee can be charged that had not been approved by the local school division.

Additionally, fees may not be charged (i) as a condition of school enrollment unless the student is not of school age or does not live within the jurisdiction; (ii) for instructional programs and activities, or nonconsumable materials required for instruction; (iii) for textbooks or textbook deposits; however, local school divisions may assess a reasonable fee for lost or damaged textbooks; (iv) for pupil transportation to and from school but may be charged for the student's pro rata cost of providing for voluntary extracurricular activities. However, fees may be charged for (i) optional services or student-selected extra curricular activities; (ii) summer school unless the summer school program is a remediation program required by the Standards of Quality; (iii) class dues; however, class dues shall not be mandatory and the school board must specify the kinds of programs and activities covered by class dues; (iv) consumable materials, such as workbooks, but the local school board must have a policy to ensure that these are furnished at a reduced price or free of charge to students who are unable to afford them; (v) the behind the wheel portion of the driver's education program; and (vi) the preparation and distribution of official paper copies of the student's transcript, provided that the school board first provides a reasonable number of copies for free and official electronic copies of transcripts at no cost. Also, a student may not be suspended or expelled for nonpayment of fees and charges.

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 720~~
~~REGULATIONS GOVERNING LOCAL SCHOOL BOARDS AND SCHOOL DIVISIONS~~

~~**8VAC20-720-10 through 8VAC20-720-70. (Reserved.)**~~ **]**

8VAC20-720-80. Student fees and charges.

A. No fees or charges may be levied on any pupil by any school board unless authorized by [regulation of] the Board of Education or [~~prescribed~~] by the [~~Code of Virginia~~ General Assembly].

B. Each local school board shall develop a policy in accordance with the requirements of the Standards of Quality, § 22.1-253.13:7 of the Code of Virginia, addressing any fees that are charged. The policy shall include the schedule of fees charged by the school division, provisions for reducing or waiving fees, and [~~sanctions~~ consequences] for nonpayment of fees. The policy and the fee schedule shall be provided to parents annually and posted on the school division's website.

C. The policy shall provide for the reduction or waiver of fees for economically disadvantaged students and students whose families are undergoing economic hardships [and are financially unable to pay them]. This shall include, but not be limited to, families receiving unemployment benefits [~~and~~ or] public assistance, including Temporary Assistance for Needy Families (TANF), [~~and food stamps~~ Supplemental Nutrition Assistance Program (SNAP), Supplemental Security Income (SSI) or] Medicaid; foster families caring for children in foster care; [~~and~~ or] families that are homeless.

D. [School divisions shall provide notice that a fee waiver may be requested, including directions as to how to apply for the waiver, each time a fee is charged.

E.] School divisions shall not charge any fees that have not been approved by the local school board.

[~~E.~~ F.] The fee policy and the fee schedule shall be consistent throughout the school division, although there may be different fee schedules [~~for~~ assessed at the] elementary, middle, and high [~~schools~~ school levels].

[~~F.~~ G.] Local school boards shall not charge fees:

1. As a condition of school enrollment, except for students who are not of school-age or who do not reside within the jurisdiction, in accordance with §§ 22.1-1 and 22.1-3 of the Code of Virginia and as provided for in § 22.1-5 of the Code of Virginia;

2. For instructional programs and activities, or materials required for instruction, except as specified in subsection [~~G~~ H] of this section;

3. For textbooks or textbook deposits; however, § 22.1-243 of the Code of Virginia permits a local school board to assess a reasonable fee or charge for lost or damaged textbooks;

4. For pupil transportation to and from school; or

5. For summer school programs or other forms of remediation required by the Standards of Quality, § 22.1-253.13:1 of the Code of Virginia.

[~~G.~~ H.] Local school boards may charge fees for the following:

1. [~~Nonmandatory~~ Optional] services, such as parking or locker rental;

2. [~~Nonmandatory~~ Student-selected] extracurricular activities;

3. Class dues; however, class dues shall not be mandatory, and the school board shall specify the kinds of programs and activities covered by class dues;

4. Field trips or educationally-related programs that are not required instructional activities;

5. [~~Deposits for musical instruments not required for instructional activities~~ Fees for musical instruments, so long as the instruction in the use of musical instruments is not part of the required curriculum];

6. Distance learning classes for enrichment and not necessary to meet the requirements for a diploma;

7. Summer school, unless the classes are required for remediation as prescribed by the Standards of Quality, § 22.1-253.13:1 of the Code of Virginia;

8. Overdue or lost or damaged library books;

9. Lost or damaged textbooks, in accordance with § 22.1-243 of the Code of Virginia; however, textbooks shall be provided free of charge;

10. Consumable materials such as workbooks, writing books, [~~and~~] drawing books [, and fine arts materials and supplies]; however, in accordance with § 22.1-243 of the Code of Virginia, the local school board shall develop a policy ensuring that workbooks, writing books, [~~and~~] drawing books [, and fine arts materials and supplies] are furnished to students who are unable to afford them at a reduced price or free of charge [~~:~~. In addition, local school boards are not authorized to charge fees to students for instructional materials, textbooks, or other materials that are not directly used by a public school student;]

11. The behind-the-wheel portion of the driver's education program in accordance with § 22.1-205 of the Code of Virginia;

12. A [fee not to exceed a] student's pro rata share of the cost of providing transportation for voluntary extracurricular activities, in accordance with § 22.1-176 of the Code of Virginia; and

13. The preparation and distribution of official paper copies of student transcripts; however, each school board shall provide a reasonable number of copies for free before a charge is levied for additional official copies. Official electronic copies of student transcripts shall be provided for free.

H. Local school boards shall not:

1. Withhold any student's scholastic report card or diploma because of nonpayment of fees and charges, in accordance with § 22.1-6 of the Code of Virginia; [~~or~~]

2. [Withhold any student's class schedule; or

3.] Suspend or expel a student for nonpayment of fees and charges.]

I. Nothing in this chapter shall be construed to prohibit the school board of any county, city, or town from making supplies, services, or materials available to pupils at cost.

J. These regulations do not address the operation of school stores or fund-raising activities where transactions are strictly voluntary.

[~~8VAC20-720-90 through 8VAC20-720-170. (Reserved.)~~]

VA.R. Doc. No. R09-1531; Filed October 23, 2012, 11:08 a.m.

TITLE 9. ENVIRONMENT

VIRGINIA WASTE MANAGEMENT BOARD

Forms

Title of Regulation: **9VAC20-81. Solid Waste Management Regulations.**

Contact Information: Debra A. Harris, Policy Planning Specialist, Department of Environmental Quality, 629 East Main Street, Richmond, VA 23219, telephone (804) 698-4209, FAX (804) 698-4346, or email debra.harris@deq.virginia.gov.

NOTICE: Forms used in administering the following regulation have been filed by the Virginia Waste Management Board. The forms are not being published; however, online users of this issue of the Virginia Register of Regulations may click on the name of the new or amended form to access it. The forms are also available from the agency contact or may be viewed at the Office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Richmond, Virginia 23219.

FORMS (9VAC20-81)

Annual Report QA/QC Submission Checklist, DEQ Form ARSC-01 (rev. 7/11).

~~Solid Waste Management Facility Permit Applicant's Disclosure Statement, DEQ Form DISC-01 (rev. 4/11).~~

~~Solid Waste Management Facility Permit Applicant's Disclosure Statement - Key Personnel, DEQ Form DISC-02 (rev. 4/11).~~

Solid Waste Management Facility Permit Applicant's Disclosure Statement, DEQ Form DISC-01 (rev. 7/12).

Solid Waste Management Facility Permit Applicant's Disclosure Statement - Key Personnel, DEQ Form DISC-02 (rev. 7/12).

Solid Waste Management Facility Disclosure Statement - Quarterly Update, DEQ Form DISC-03 (rev. 7/12).

Request for Certification (Local Government), DEQ Form SW-11-1 (rev. 7/11).

Special Waste Disposal Request, DEQ Form SWDR (rev. 1/12).

Solid Waste Part A Application, DEQ Form SW PTA (rev. 3/11).

Solid Waste Disposal Facility Part B Application, DEQ Form SW PTB (rev. 3/11).

Solid Waste Information and Assessment Program - Reporting Table, DEQ Form 50-25 (rev. 12/11).

Instructions for Completing Form DEQ 50-25 (rev. 12/11).

~~Yard Waste Composting Notice of Intent and Certification, DEQ Form YW-1.~~

Exempt Yard Waste Composting Annual Report, DEQ Form YW-2 (rev. 7/11).

Exempt Yard Waste Compost Facility – Notice of Intent and Certification, DEQ Form YW-3 (rev. 7/11).

Exempt Yard Waste & Herbivorous Manures Compost Facility – Notice of Intent and Certification, DEQ Form YW-4 (rev. 7/11).

VA.R. Doc. No. R13-3394; Filed October 19, 2012, 11:49 a.m.

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TITLE 10. FINANCE AND FINANCIAL INSTITUTIONS

STATE CORPORATION COMMISSION

Proposed Regulation

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

Title of Regulation: **10VAC5-160. Rules Governing Mortgage Lenders and Brokers (amending 10VAC5-160-10, 10VAC5-160-20, 10VAC5-160-50, 10VAC5-160-60, 10VAC5-160-90, 10VAC5-160-100; adding 10VAC5-160-110).**

Statutory Authority: §§ 6.2-1613 and 12.1-13 of the Code of Virginia.

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

Public Comment Deadline: December 7, 2012.

Agency Contact: E.J. Face, Jr., Bureau of Financial Institutions Commissioner, State Corporation Commission, P.O. Box 640, Richmond, VA 23218, telephone (804) 371-9659, FAX (804) 371-9416, or email joe.face@scc.virginia.gov.

Summary:

The proposed regulations (i) clarify that a person engaged solely in the business of a loan processor or underwriter is not a mortgage broker subject to licensure under Chapter 16 of Title 6.2 of the Code of Virginia; (ii) set forth the requirements for a licensee's use of third party loan processors and underwriters; (iii) define the term "refinancing"; (iv) prohibit licensees from making any false, deceptive, or misleading statement to borrowers or the bureau; and (v) require licensees to use mortgage loan originators who are licensed, covered by the licensee's surety bond, sponsored by the licensee in the Nationwide Mortgage Licensing System and Registry ("Registry"), and are either an employee or an exclusive agent of the licensee. In addition, the proposed regulations amend provisions pertaining to the retention of records; providing

notices and written reports through the Registry; updating of records within the Registry; advertising; and other matters.

AT RICHMOND, OCTOBER 18, 2012

COMMONWEALTH OF VIRGINIA, ex rel.

STATE CORPORATION COMMISSION

CASE NO. BFI-2012-00068

Ex Parte: In re: Mortgage Lenders and Mortgage Brokers

ORDER TO TAKE NOTICE

Section 6.2-1613 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 16 (§ 6.2-1600 et seq.) of Title 6.2 of the Code of Virginia ("Chapter 16"). The Commission's regulations governing licensed mortgage lenders and mortgage brokers ("licensees") are set forth in Chapter 160 of Title 10 of the Virginia Administrative Code ("Chapter 160").

The Bureau of Financial Institutions ("Bureau") has submitted to the Commission proposed amendments to Chapter 160. The proposed regulations: (i) clarify that a person engaged solely in the business of a loan processor or underwriter is not a mortgage broker subject to licensure under Chapter 16; (ii) set forth the requirements for a licensee's use of third party loan processors and underwriters; (iii) define the term "refinancing"; (iv) prohibit licensees from making any false, deceptive, or misleading statement to borrowers or the Bureau; and (v) require licensees to use mortgage loan originators who are licensed, covered by the licensee's surety bond, sponsored by the licensee in the Nationwide Mortgage Licensing System and Registry ("Registry"), and who are either an employee or an exclusive agent of the licensee. Further, the proposed regulations make a number of changes pertaining to retention of records, providing notices and written reports through the Registry, updating of records within the Registry, advertising, and other matters.

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 January 1, 2013.

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 December 7, 2012. 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-2012-00068. 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 forthwith send by e-mail or U.S. mail a copy of this Order, together with a copy of the proposed regulations, to all licensed mortgage lenders, licensed mortgage brokers, and such other interested parties as he may designate.

10VAC5-160-10. Definitions.

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

"Advertisement" means a commercial message in any medium that promotes, directly or indirectly, a mortgage loan. The term includes a communication sent to a consumer as part of a solicitation of business, but excludes messages on promotional items such as pens, pencils, notepads, hats, calendars, etc., as well as rate sheets or other information distributed or made available solely to other businesses.

"Affiliate" for purposes of subdivision 3 of § 6.2-1602 of the Code of Virginia means an entity of which 25% or more of the voting shares or ownership interest is held, directly or indirectly, by a company that also owns a bank, savings institution, or credit union.

"Bureau," "commission," and "commissioner" shall have the meanings ascribed to them in § 6.2-100 of the Code of Virginia.

"Chapter 16" means Chapter 16 (§ 6.2-1600 et seq.) of Title 6.2 of the Code of Virginia.

~~"Commission" and "commissioner" shall have the meanings ascribed to them in § 6.2-100 of the Code of Virginia.~~

"Chapter 17" means Chapter 17 (§ 6.2-1700 et seq.) of Title 6.2 of the Code of Virginia.

"Commitment" means a written offer to make a mortgage loan signed by a person authorized to sign such offers on behalf of a mortgage lender.

"Commitment agreement" means a commitment accepted by an applicant for a mortgage loan, as evidenced by the applicant's signature thereon.

"Commitment fee" means any fee or charge accepted by a mortgage lender, or by a mortgage broker for transmittal to a

mortgage lender, as consideration for binding the mortgage lender to make a mortgage loan in accordance with the terms of a commitment or as a requirement for acceptance by the applicant of a commitment, but the term does not include fees paid to third persons or interest.

"Dwelling" means one- to four-family residential property located in the Commonwealth.

"Fees paid to third persons" means the bona fide fees or charges paid by the applicant for a mortgage loan to third persons other than the mortgage lender or mortgage broker, or paid by the applicant to, or retained by, the mortgage lender or mortgage broker for transmittal to such third persons in connection with the mortgage loan, including, but not limited to, recording taxes and fees, reconveyance or releasing fees, appraisal fees, credit report fees, attorney fees, fees for title reports and title searches, title insurance premiums, surveys and similar charges.

"Licensee" means a person licensed under Chapter 16.

"Loan processor or underwriter" means a person who, with respect to the origination of a residential mortgage loan, performs the following duties at the direction of and subject to the supervision and instruction of a licensed or exempt mortgage lender or mortgage broker: (i) receiving, collecting, distributing, or analyzing information common for the processing or underwriting of a residential mortgage loan or (ii) communicating with a consumer to obtain the information necessary for the processing or underwriting of a residential mortgage loan. A loan processor or underwriter does not include a person who (i) communicates with a consumer regarding a prospective residential mortgage loan prior to the consumer submitting a residential mortgage loan application, (ii) takes an application for or offers or negotiates the terms of a residential mortgage loan, or (iii) counsels consumers about residential mortgage loan terms. For purposes of this definition, the phrase "takes an application for or offers or negotiates the terms of a residential mortgage loan" shall be construed in accordance with subdivisions B 1 and 2 of 10VAC5-161-20.

"Lock-in agreement" means a written agreement between a mortgage lender, or a mortgage broker acting on behalf of a mortgage lender, and an applicant for a mortgage loan that establishes and sets an interest rate and the points to be charged in connection with a mortgage loan that is closed within the time period specified in the agreement. A lock-in agreement can be entered into before mortgage loan approval, subject to the mortgage loan being approved and closed, or after such approval. A commitment agreement that establishes and sets an interest rate and the points to be charged in connection with a mortgage loan that is closed within the time period specified in the agreement is also a lock-in agreement. The interest rate that is established and set by the agreement may be either a fixed rate or an adjustable rate.

"Lock-in fee" means any fee or charge accepted by a mortgage lender, or by a mortgage broker for transmittal to a mortgage lender, as consideration for making a lock-in agreement, but the term does not include fees paid to third persons or interest.

"Mortgage lender," "mortgage broker," and "mortgage loan" shall have the meanings ascribed to them in § 6.2-1600 of the Code of Virginia. For purposes of Chapter 16 and this chapter, the term "mortgage broker" does not include a person engaged in the business of a loan processor or underwriter provided that such person is not engaged in any other activities for which a mortgage broker license is required.

"Mortgage loan originator," "Nationwide Mortgage Licensing System and Registry," ~~and~~ "Registry," and "residential mortgage loan" shall have the meanings ascribed to them in § 6.2-1700 of the Code of Virginia.

"Personal, family or household purposes" for purposes of § 6.2-1600 of the Code of Virginia means that the individual obtaining the loan intends to use the proceeds to build or purchase a dwelling that will be occupied by such individual or another individual as their temporary or permanent residence. The term includes a loan used to build or purchase a dwelling that will be (i) improved or rehabilitated by or on behalf of the purchaser for subsequent sale to one or more other individuals who will reside in the dwelling on a temporary or permanent basis, or (ii) leased by the purchaser to one or more other individuals who will reside in the dwelling on a temporary or permanent basis.

"Points" means any fee or charge retained or received by a mortgage lender or mortgage broker stated or calculated as a percentage or fraction of the principal amount of the loan, other than or in addition to fees paid to third persons or interest.

"Reasonable period of time" means that period of time, determined by a mortgage lender in good faith on the basis of its most recent relevant experience and other facts and circumstances known to it, within which the mortgage loan will be closed.

"Refinancing" for purposes of Chapter 16 and this chapter means an exchange of an old debt for a new debt, as by negotiating a different interest rate or term or by repaying an existing loan with money acquired from a new loan. "Refinancing" includes any loan modification.

"Senior officer" for purposes of §§ 6.2-1605, 6.2-1606, 6.2-1607, and 6.2-1608 of the Code of Virginia means an individual who has significant management responsibility within an organization or otherwise has the authority to influence or control the conduct of the organization's affairs, including but not limited to its compliance with applicable laws and regulations.

"Subsidiary" for purposes of subdivision 3 of § 6.2-1602 of the Code of Virginia means an entity of which 25% or more

of the voting shares or ownership interest is held, directly or indirectly, by a bank, savings institution, or credit union.

10VAC5-160-20. Operating rules.

A licensee shall conduct its business in accordance with the following rules:

1. No licensee shall (i) misrepresent the qualification requirements for a mortgage loan or any material loan terms ~~or~~; (ii) make false or misleading statements to induce an applicant to apply for a mortgage loan ~~or to induce an applicant to,~~ enter into any commitment agreement or lock-in agreement ~~or to induce an applicant to~~, or pay any commitment fee or lock-in fee in connection therewith; or (iii) provide any other information to a borrower or prospective borrower that is false, misleading, or deceptive. A "material loan term" means the loan terms required to be disclosed to a consumer pursuant to (i) the Truth in Lending Act (15 USC § 1601 et seq.), and regulations and official commentary issued thereunder, as amended from time to time, (ii) § 6.2-406 of the Code of Virginia, and (iii) 10VAC5-160-30. A misrepresentation or false or misleading statement resulting directly from incorrect information furnished to a licensee by a third party, or a good-faith misunderstanding of information furnished by a third party, shall not be considered a violation of this section if the licensee has supporting documentation thereof and the licensee's reliance thereon was reasonable.

2. No licensee shall retain any portion of any fees or charges imposed upon consumers for goods or services provided by third parties. All moneys received by a licensee from an applicant for fees paid to third persons shall be accounted for separately, and all disbursements for fees paid to third persons shall be supported by adequate documentation of the services for which such fees were or are to be paid. All such moneys shall be deposited in an escrow account in a bank, savings institution, or credit union segregated from other funds of the licensee.

3. The mortgagor who obtains a mortgage loan shall be entitled to continue to make payments to the transferor of the servicing rights under a mortgage loan until the mortgagor is given written notice of the transfer of the servicing rights by the transferor. The notice shall specify the name and address to which future payments are to be made and shall be mailed or delivered to the mortgagor at least 10 calendar days before the first payment affected by the notice.

4. If a person has been or is engaged in business as a mortgage lender or mortgage broker and has filed a bond with the commissioner, as required by § 6.2-1604 of the Code of Virginia, such bond shall be retained by the commissioner notwithstanding the occurrence of any of the following events:

a. The person's application for a license is withdrawn or denied;

b. The person's license is surrendered, suspended, or revoked; or

c. The person ceases engaging in business as a mortgage lender or mortgage broker.

5. ~~Within~~ Pursuant to § 6.2-1621 of the Code of Virginia, within 15 days of becoming aware of the occurrence of any of the ~~following~~ events enumerated in this subdivision, a licensed mortgage lender or mortgage broker shall file a written report with the commissioner describing such event and its expected impact, if any, on the activities of the licensee in the Commonwealth. If the Registry enables licensees to submit the information required by this subdivision, then submission of this information through the Registry shall satisfy the requirement for a written report:

a. The licensee files for bankruptcy or reorganization.

b. Any governmental authority institutes revocation or suspension proceedings against the licensee, or revokes or suspends a mortgage-related license held or formerly held by the licensee.

c. Any governmental authority takes (i) formal regulatory or enforcement action against the licensee relating to its mortgage business or (ii) any other action against the licensee relating to its mortgage business where the total amount of restitution or other payment from the licensee exceeds $20,000. A licensee shall not be required to provide the commissioner with information about such event to the extent that such disclosure is prohibited by the laws of another state.

d. Based on allegations by any governmental authority that the licensee violated any law or regulation applicable to the conduct of its licensed mortgage business, the licensee enters into, or otherwise agrees to the entry of, a settlement or consent order, decree, or agreement with or by such governmental authority.

e. The licensee surrenders its license to engage in any mortgage-related business in another state in lieu of threatened or pending license revocation, license suspension, or other regulatory or enforcement action.

f. The licensee is denied a license to engage in any mortgage-related business in another state.

g. The licensee or any of its employees, officers, directors, ~~or~~ principals, or exclusive agents is indicted for a felony.

h. The licensee or any of its employees, officers, directors, ~~or~~ principals, or exclusive agents is convicted of a felony.

i. The licensee or any of its employees, officers, directors, principals, or exclusive agents is convicted of a misdemeanor involving fraud, misrepresentation, or deceit.

6. No licensee shall inform a consumer that such consumer has been or will be "preapproved" or "pre-approved" for a mortgage loan unless the licensee contemporaneously provides the consumer with a separate written disclosure (in at least 10-point type) that (i) explains what preapproved means; (ii) informs the consumer that the consumer's loan application has not yet been approved; (iii) states that a written commitment to make a mortgage loan has not yet been issued; and (iv) advises the consumer what needs to occur before the consumer's loan application can be approved. This provision shall not apply to advertisements subject to 10VAC5-160-60. In the case of a preapproval initially communicated to a consumer by telephone, the licensee shall provide the written disclosure to the consumer within three business days.

7. ~~No~~ A licensee shall not permit any individual ~~who is not licensed as a mortgage loan originator pursuant to Chapter 17 (§ 6.2-1700 et seq.) of Title 6.2 of the Code of Virginia to, on behalf of the licensee,~~ to take an application for or offer or negotiate the terms of a residential mortgage loan ~~as defined in § 1503(8) of the federal Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (P.L. 110-289), that is secured by real property located in the Commonwealth~~ on behalf of the licensee unless: (i) the individual is licensed as a mortgage loan originator pursuant to Chapter 17; (ii) the individual is covered by the licensee's surety bond; (iii) the licensee has submitted a sponsorship request for such individual through the Registry; and (iv) the individual is either (a) a bona fide employee of the licensee, or (b) an exclusive agent of the licensee pursuant to a written agreement with the licensee and the licensee has agreed to such conditions relating to its use of exclusive agents as may be prescribed by the bureau. The phrase "take an application for or offer or negotiate the terms of a residential mortgage loan" shall be construed in accordance with subdivisions B 1 and 2 of 10VAC5-161-20.

8. ~~Beginning April 1, 2011, every~~ Every licensee shall disclose on any application provided to the borrower associated with a Virginia residential mortgage loan: (i) the ~~licensee's~~ unique identifier assigned by the Registry to the licensed mortgage lender or mortgage broker that took the initial mortgage loan application; and (ii) the unique identifier assigned by the Registry to ~~any~~ the licensed mortgage loan originator who took the initial mortgage loan application ~~for the loan~~.

9. A licensee may outsource its loan processing or underwriting activities to a third party loan processor or underwriter pursuant to a written agreement with the loan processor or underwriter. Prior to entering into an agreement, the licensee shall conduct a due diligence review of the third party loan processor or underwriter. The agreement shall (i) require the loan processor or underwriter to comply with all applicable state and federal laws and regulations; (ii) require the loan processor or underwriter to permit the commission to investigate or examine its business pursuant to § 6.2-1611 of the Code of Virginia; and (iii) prohibit the loan processor or underwriter from subcontracting to another person, other than its bona fide employees, any of the services specified in the agreement to be performed on behalf of the licensee. A copy of the written agreement shall be retained by the licensee for at least three years after the agreement has been terminated by either party. The licensee shall be responsible for implementing and maintaining a reasonable program to monitor any third party loan processor or underwriter performing services on its behalf.

10. 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.

11. Every licensee shall comply with Chapter 16, this chapter, and all other state and federal laws and regulations applicable to the conduct of its business.

10VAC5-160-50. Responding to requests from Bureau of Financial Institutions; providing false, misleading, or deceptive information; record retention.

A. If the bureau requests information from an applicant to complete a deficient application filed under §§ 6.2-1603, 6.2-1607, or 6.2-1608 of the Code of Virginia and the information is not received within 60 days of the request, the application shall be deemed abandoned unless a request for an extension of time is received and approved by the bureau prior to the expiration of the 60-day period.

B. When the ~~Bureau of Financial Institutions (bureau)~~ bureau requests a written response, books, records, documentation, or other information from a ~~mortgage lender or mortgage broker (licensee)~~ 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.

~~B.~~ Requests made by the bureau pursuant to this subsection ~~A~~ are deemed to be in furtherance of the bureau's investigation and examination authority provided for in § 6.2-1611 of the Code of Virginia. ~~Failure to comply with~~

~~subsection A may result in civil penalties, license suspension, or license revocation.~~

C. A licensee shall not provide any information to the bureau, either directly or through the Registry, that is false, misleading, or deceptive.

D. A licensee shall maintain in its licensed offices all books, accounts, and records required by Chapter 16 and this chapter.

10VAC5-160-60. Advertising.

A. Every advertisement used by, or published on behalf of, a licensed mortgage lender or mortgage broker shall clearly and conspicuously disclose the following information:

1. The name of the mortgage lender or mortgage broker as set forth in the license issued by the commission.

~~2. A statement that the mortgage lender or mortgage broker is licensed by the "Virginia State Corporation Commission."~~

~~3.~~ 2. The ~~license number~~ abbreviation "NMLS ID #" followed immediately by both the unique identifier assigned by the ~~commission~~ Registry to the mortgage lender or mortgage broker ~~(i.e., MB XXX, ML XXX, or MLB XXX)~~ and the address for the NMLS Consumer Access website in parenthesis. For example: NMLS ID # 999999 (www.nmlsconsumeraccess.org).

~~4.~~ 3. If an advertisement contains a rate of interest, a statement that the stated rate may change or not be available at the time of loan commitment or lock-in.

~~5.~~ 4. If an advertisement contains specific information about a consumer's existing mortgage loan and such information was not obtained from the consumer, a statement identifying the source of such information (e.g., public court records, credit reporting agency, etc.).

B. No mortgage lender or mortgage broker shall deceptively advertise a mortgage loan, make false or misleading statements or representations, or misrepresent the terms, conditions, or charges incident to obtaining a mortgage loan.

C. No mortgage lender or mortgage broker shall use or cause to be published an advertisement that states or implies the following:

1.The mortgage lender or mortgage broker is affiliated with, or an agent or division of, a governmental agency, depository institution, or other entity with which no such relationship exists; or

2. A consumer has been or will be "preapproved " or "pre-approved" for a mortgage loan, unless the mortgage lender or mortgage broker (i) discloses on the face of the advertisement in at least 14-point bold type that "THIS IS NOT A LOAN APPROVAL" and (ii) clearly and conspicuously discloses the conditions and/or qualifications associated with such preapproval. This provision is intended to supplement the requirements of the Fair Credit Reporting Act, 15 USC § 1681 et seq., relating to firm offers of credit.

D. A mortgage lender or mortgage broker shall not use or cause to be published any advertisement that gives a consumer the false impression that the advertisement is being sent by the consumer's current noteholder or lienholder. If an advertisement contains the name of the consumer's current noteholder or lienholder, it shall not be more conspicuous than the name of the mortgage lender or mortgage broker using the advertisement.

E. A mortgage lender or mortgage broker shall not deliver or cause to be delivered to a consumer any envelope or other written material that gives the false impression that the mailing or written material is an official communication from a governmental entity, unless required by the United States Postal Service.

F. If an advertisement states or implies that a consumer can reduce his monthly payment by refinancing his current mortgage loan, but as a result of such refinancing, the consumer's total finance charges may be higher over the life of the loan, a mortgage lender or mortgage broker shall clearly and conspicuously disclose to the consumer that by refinancing the consumer's existing loan, the consumer's total finance charges may be higher over the life of the loan.

G. Every advertisement used by, or published on behalf of, a mortgage lender or mortgage broker shall comply with the disclosure requirements for advertisements contained in the Truth in Lending Act and Regulation Z, 12 CFR Part 226.

H. For purposes of this section, the term "clearly and conspicuously" means that a required disclosure is reasonably understandable, prominently located, and readily noticeable by a potential borrower of ordinary intelligence.

I. Every mortgage lender and mortgage broker 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.

10VAC5-160-90. ~~National~~ Nationwide Mortgage Licensing System and Registry.

A. ~~Beginning January 3, 2011, applications~~ Applications for a mortgage lender or mortgage broker license shall be made through the Registry in accordance with instructions provided by the Commissioner. The Commissioner may provide these instructions through the Registry, on the Commission's Internet web site, or by any other means the Commissioner deems appropriate.

B. The Commissioner shall notify all licensees no later than January 1 of each calendar year of the information required to be included in the annual report to be submitted by each licensee pursuant to § 6.2-1610 of the Code of Virginia.

C. Entities exempt from the requirement for licensure under Chapter 16 that supervise mortgage loan originators licensed pursuant to Chapter 17 ~~(§ 6.2-1700 et seq.) of Title 6.2 of the Code of Virginia~~ may obtain a unique identifier through the Registry.

~~D. All licensees holding a license under Chapter 16 prior to January 1, 2011, shall obtain such unique identifier and provide all required information to the Registry no later than April 1, 2011.~~

~~E.~~ D. Every licensee shall maintain current information in its records with the Registry. ~~Any~~ Except as provided in subsection E of this section, changes to the licensee's address, principal officers, or any other information in the Registry shall be updated by the licensee as soon as is practicable, but in no event later than five business days from when the change takes effect.

E. A licensee shall update its sponsorship information in the Registry within five days after the occurrence of either of the following events: (i) a mortgage loan originator becomes a bona fide employee or exclusive agent of the licensee or (ii) a mortgage loan originator ceases to be a bona fide employee or exclusive agent of the licensee.

F. If (i) any provision of Chapter 16 or this chapter requires a licensee to provide the bureau or commissioner with a written notice and (ii) the Registry enables licensees to submit such notice through the Registry, then a licensee shall be deemed to have complied with the written notice requirement if the licensee timely submits the required notice through the Registry.

10VAC5-160-100. Enforcement.

A. Failure to comply with any provision of Chapter 16 or this chapter may result in civil penalties, license suspension, ~~or~~ license revocation, the entry of a cease and desist order, or other appropriate enforcement action.

B. Pursuant to § 6.2-1624 of the Code of Virginia, a ~~licensee~~ person required to be licensed under Chapter 16 shall be subject to a civil penalty of up to $2,500 for every violation of Chapter 16, this chapter, or other law or regulation applicable to the conduct of the ~~licensee's~~ person's business. Furthermore, if a ~~licensee~~ person violates any provision of Chapter 16, this chapter, or other law or regulation applicable to the conduct of the ~~licensee's~~ person's business in connection with multiple borrowers, loans, or prospective loans, the ~~licensee~~ person shall be subject to a separate civil penalty for each borrower, loan, or prospective loan. For example, if a ~~licensee~~ person makes five loans and the ~~licensee~~ person violates two provisions of this chapter in connection with each of the five loans, there would be a total of 10 violations and the ~~licensee~~ person would be subject to a maximum civil penalty of $25,000.

10VAC5-160-110. Commission authority.

The commission may, at its discretion, waive or grant exceptions to any provision of this chapter for good cause shown.

VA.R. Doc. No. R13-3440; Filed October 22, 2012, 5:10 p.m.

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TITLE 12. HEALTH

STATE BOARD OF HEALTH

Proposed Regulation

Title of Regulation: **12VAC5-115. Virginia Immunization Information System (adding 12VAC5-115-10 through 12VAC5-115-80).**

Statutory Authority: § 32.1-46.01 of the Code of Virginia.

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: January 18, 2013.

Agency Contact: James Farrell, Department of Health, 109 Governor St., Richmond, VA 23219, telephone (804) 864-8055, or email james.farrell@vdh.virginia.gov.

Basis: Section 32.1-46.01 of the Code of Virginia requires the Board of Health to establish the Virginia Immunization Information System (VIIS), a statewide immunization registry that consolidates patient immunization histories from birth to death into a complete, accurate, and definitive record that may be made available to participating health care providers throughout Virginia, to the extent funds are appropriated by the General Assembly or otherwise made available. Section 32.1-46.01 of the Code of Virginia further requires the Board of Health to promulgate regulations to implement the VIIS.

Purpose: Chapters 643 and 684 of the 2005 Acts of Assembly established the VIIS, a statewide immunization information system that contains birth-to-death immunization histories of participating clients and merges this data from all healthcare providers for that patient into one record. This consolidated record, which is available to participating health care providers in Virginia, will help providers identify appropriate immunizations to give their patients. It will help to increase immunization rates and protect the public health of all citizens of Virginia in the following ways: (i) ensure that children receive vaccines appropriately, as currently recommended by the Advisory Committee on Immunization Practices; (ii) prevent the under-immunization and over-immunization of children; (iii) generate parental reminders, recall notices, and manufacturer recalls; (iv) produce immunization coverage reports; (v) identify areas of under-immunized populations for educational purposes and other immunization rate improvement activities; and (vi) provide, in the event of a public health emergency, a mechanism for

tracking the distribution and administration of immunizations, immune globulins, or other preventive medications or emergency treatments.

Substance: Regulations for VIIS cover five main areas: (i) authorized participants of VIIS and their registration procedure; (ii) data entry by participants either through user interface or data exchange; (iii) requirements for patient confidentiality and system security; (iv) approved and nonapproved use of VIIS data; and (v) use of VIIS in a public health emergency.

Issues: VIIS regulations will pose no disadvantage to the public or the Commonwealth. Many advantages will occur for both the general public and to the Commonwealth. An accurate patient immunization record allows health care providers to diagnose vaccine preventable diseases more effectively and to recommend immunizations that ensure patients receive all the age-appropriate vaccines recommended by ACIP. Accurate immunization information also decreases costs by preventing unnecessary duplicated immunizations, reminding clients of vaccines that are due or were recalled by the manufacturer, and identifying areas of need for increased education and other activities that may lead to improved immunization coverage rates.

There are also benefits to parents or guardians, which include the following:

1. Removes the need to provide their child's immunization record to the healthcare provider(s);

2. Prevents additional visits to the child's provider(s) by identifying all age-appropriate immunizations that may be given during the current visit;

3. Provides emergency department ability to assess the child's immunization status at the time of an injury;

4. Provides information needed to create reminder/recall notices for recommended immunizations that are due or overdue;

5. Simplifies the process for obtaining the child's immunization history for admission to schools, daycares, camps, etc.;

6. Enables identification of and recall notification to the child who received a vaccine that was later recalled or did not receive a recommended vaccine due to short supply;

7. Guarantees lifetime access to the clients immunization history even if the health care providers office is no longer in operation.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. Pursuant to Section 32.1-46.01 of the Code of Virginia, the Board of Health proposes to establish regulations for the Virginia Immunization Information System.

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

Estimated Economic Impact. SB 1132 and HB 2519 passed by the 2005 General Assembly mandated the Board of Health to establish the Virginia Immunization Information System (VIIS). A pilot system was initiated in 2006 and the VIIS became fully operational in 2009. Participation in VIIS is voluntary. Participants enter immunization histories of their clients into the system and share the information on consenting individuals with other healthcare providers or users. Even though VIIS is statewide, it is capable of interacting with immunization systems of other states.[1] In other words, it makes it possible to access immunization records nationwide. The web based information system is developed and provided by the federal government free of charge. The federal government also pays for the operation of the system. Thus, all the start up costs as well as operating costs of VIIS is paid 100% by federal funds.

This analysis heavily borrows from a document titled "VIIS Economic Impact" which is authored by the Virginia Department of Health (VDH) to identify the costs and the benefits of VIIS. According to VDH, annual operation costs of VIIS are approximately $2.3 million per year. These costs include management of the system by an outside vendor; salaries of state employees necessary for program management, including the planning and performing of daily operations as well as quality assurance and improvement activities, and recruitment, training and monitoring of participants; supplies; hardware upgrades for the application's successful operation; and travel expenses for continuing education of staff and for necessary visits to the participant's offices.

Note that none of these costs are borne by the Commonwealth. Thus, the federal funds spent on VIIS represent a net economic gain for Virginia. The influx of these federal funds is expected to have an expansionary economic impact on the Commonwealth's economy by creating additional employment and additional demand for goods and services.

Participation in VIIS has some cost implications for the users. If an election to participate is made, the costs incurred by the users include a computer with internet access; staff time to complete registration and security forms for participation; training and customizing the application for their facility; adding users within their facility; and if they elect to do so, staff time for entering the previous immunization history of their clients. The web based application is available to the users free of charge. After VIIS access is granted to the provider, the staff must enter inventory into the system and when giving an immunization, register the client (if the client does not already exist in the system) and enter their immunization data. VDH estimates that although there is some initial setup staff time involved, the immunization information system will eventually save the practice time.

According to VDH, other states using an immunization information system have seen that the users find it to be more efficient and cost-saving because their billing systems are improved and inventory is better managed. Also, participation may make users eligible for federal grants.[2]

VDH reports that the annual cost per child of using immunization registries varies according to the differences in study methods and the size of the patient population. A study of 16 immunization registries in the United States in 1997 estimated the average cost per child was $3.91 per year.[3] This was similar to a Center for Disease Control (CDC) study from 1998 of three registries that estimated the cost per child was $3.38 to $6.15/year. Additionally CDC conducted another survey of 24 registries in 1999 with an estimate of $5.18 per child per year.[4] However, it is worth noting that since the program is voluntary, by participating the users reveal that the expected benefits to them are greater than the expected costs.

The potential benefits of VIIS include following:

Providing accurate immunization records. According to VDH, national studies by CDC have indicated that participation in an immunization information system can provide a net benefit by improving the efficiency of the immunization delivery process. In the absence of an information system, when a child receives an immunization, the provider updates the information on an immunization card that is presented to the child's parent/guardian. Often this card is lost, forgotten or not kept up to date. Without official documentation, physicians are required to vaccinate children with the age-appropriate immunizations to assure that they are protected against disease. Thus, accurate immunization records help prevent under and over immunization of children. Also, an additional benefit would be that hospital emergency room patients would be able to quickly identify the vaccination status of the emergency patient and decide whether a vaccine dose is needed.

Identifying age-appropriate vaccines for specific client. Prior to VIIS, providers did not have a consistent method for accurately assessing their clients for age-appropriate vaccines recommended by Advisory Committee on Immunization Practices (ACIP). The childhood schedule for age-appropriate vaccines has become more complicated as additional vaccines are added to these recommendations each year. Most providers do not have time to learn all of the vaccines and their recommendations. Currently, 16 to 20 vaccine doses are recommended before a child is 18 months of age. There is an ACIP tracking schedule within VIIS that identifies the age-appropriate vaccines to give to the client at each visit. VIIS takes the date of birth for the specific client and looks at what the client has already received and lists what vaccines are recommended at the current visit and in the future. VIIS has the ability to remind or recall children who are due or overdue for vaccines.

Identifying and contacting recipients of recalled vaccines or vaccine shortages. In VIIS, patients can be identified and recalled for vaccines they received that are later recalled by a manufacturer (due to contamination, decreased potency, etc.) or, persons whose immunization was deferred due to vaccine shortages that has now been resolved.

Improving inventory management. VIIS has an inventory module which streamlines vaccine management and improves accountability of both public and private vaccine. The application displays expiring vaccine lots, preventing vaccine waste by allowing for transfer of these lots to other clinics that can use them. It also encourages the provider to order vaccine doses in quantities based on their real need, and therefore reducing vaccine wastage.

Identifying pockets of need. VIIS can also be used to compute immunization rates and identify pockets of need in the state, allowing identification of high-risk groups for targeted outreach. The application is capable of assessing specific vaccine and producing reports that monitor new vaccine uptake.

Use in a public health emergency. VIIS is already being used to record H1N1 influenza vaccine given in the state of Virginia. The application is capable of posting messages or alerts on the main page for all users to view. It also can be used to link to other states immunization information systems to find immunization records.

Providing official immunization records for parents/guardians. For enrollment in camps, daycares, schools, colleges, employment in the health care field, and other circumstances, it is necessary to present an official immunization record. VIIS can provide these reports to parents and guardians.

Adding to the use of health information technology. According to VDH, much attention in health care has been devoted to the development and use of an electronic health records (EHR); however this process has been slow in its development. Many of the modules that are included in an EHR are stand-alone systems such as laboratory, scheduling, transcription and immunization registries. They all need to be integrated into one system to improve the quality and efficiency of health care.[5] An IIS has been described as the first step in creating such systems.[6] VIIS plays an important role in advancing the development of health information technology.

Improving immunization rates. The ultimate goal of VIIS is to improve the immunization rates in all citizens of Virginia. Reports vary about whether an immunization information system does improve immunization rates nationally.[7] However, many studies indicate an improvement in immunization rates, comprehensive care and accuracy of data. Oregon improved its coverage rates from 32% to 36% as a result of having more accurate, up-to-date immunization data, Minnesota from 88.2% to 95.7% within one year of implementation of its immunization information system and Arizona from 45% to 90% through a combination of better records and additional immunizations.[8 9]

Estimated direct savings to the Commonwealth by changing existing programs. Currently, five million Virginians are enrolled in VIIS and 4 million of these have at least one immunization recorded as of January 5, 2010 (as of September 27, 2010, 4.6 million Virginians have at least one immunization of the 30 million immunizations in VIIS). Once VIIS is fully populated with both demographic and immunization data from the users or data exchange, there would be significant savings due to changes for many existing state programs. These savings are discussed below:

Eliminating duplicate Hep B doses. By having a complete immunization record from multiple providers, duplicate immunizations can be eliminated or greatly reduced. Every year, approximately 100,000 children are born in Virginia and are given the Hepatitis B vaccine. This vaccine is a 3-dose series, but often because of poor documentation, a child receives an extra dose. The federal contract cost of Hep B is $9.75. Using a conservative rate of 10% of children receiving an extra dose, the cost savings achieved by eliminating this extra dose is $97,500.

Eliminating duplicate vaccines. A 2000 study by Feikema et al[10] reported that up to 21% of all children received at least one extra immunization before their third birthday. An unpublished study by CDC[11], performed from 2000-2006, found the rate in children to be about 10%. Although there are no studies documenting the number of duplicates in adolescents, a similar rate of 10% is assumed. Based on the assumed 10% extra immunization rate and according to a 2009 report from webVISION, the VDH information system, the annual cost of 8 vaccines[12] given by VDH at the federal contract prices is estimated to be $585,920.

Vaccine audits of public vaccine inventory. The federal granting agency (CDC) mandates that each state conduct accountability audits of vaccine usage. Currently each user must submit manual reports of their vaccine inventory on a periodic basis. Then the state staff must aggregate the reports manually to account for public vaccine. VIIS will automatically calculate and produce this report on a provider level and the staff will be capable of exporting the information into a spreadsheet for further analysis. A 2007 study performed by the CDC[13] at the Utah Department of Health found that the median cost savings to the state health department to process these reports could be as much as $11,740 annually. Utah has 72 practices using public vaccine. The Virginia has 900 practices or 12.5 times that of Utah. Having this aggregate report automated represents a cost savings of $146,750.

Automatic reporting of spoilage, mishandling or waste of public vaccine. In addition, providers using public vaccine prepare manual accountability reports of their vaccine wastage, spoilage and mishandling. This information is then entered into a worksheet to produce aggregate numbers for the state. With VIIS, information for each participant can be assessed from the application. Approximately 1,140 hours of staff time per year valued at $22,500 is estimated to be saved statewide.

Reducing orders of public vaccine by VDH. Through VIIS, providers could more accurately determine the doses of public vaccine that are needed in their practice by viewing what they have used in the past. This greater efficiency reduces wastage of public vaccine and eliminates any unnecessary orders by the staff to the national vaccine distribution center. In 2008, there were 167 orders per week. Assuming that the reduction is 10%, 17 orders/week, or 884 orders/year could be eliminated. It takes approximately 15 minutes to process an order. Using a rate of $20/hour for staff, $5 is saved for each order that is eliminated at a total cost savings of $4,420.

Providing immunization assessment reports to participants. Currently the staff must perform manual assessments of the immunization coverage levels of their participants. This requires a visit to the practice or health department, pulling medical records, entering the immunization information onto their laptop, and re-filing the charts. During 2008, there were 360 assessment visits performed. VIIS is capable of producing assessment reports for each provider. By doing this, not only is travel sometimes eliminated (if this is the only purpose of the visit), but approximately 2 to 3 hours of work per visit will be prevented. At a rate of $20/hour, the cost savings is 720 hours or $14,400.

Savings in annual state immunization rate assessment survey. VDH performs an annual assessment of the immunization rates of children entering kindergarten (KG). Currently, VDH randomly selects schools with KGs from lists provided by Department of Education and Virginia Council of Private Education. VDH then notifies the selected schools and their corresponding health districts. The immunization nurse from the local health department contacts the assigned school and schedules a time to select immunization records of 25 students. The immunizations of these children are then entered using a laptop computer and the records are re-filed. In Virginia, there are 1,142 public and 334 private schools that have kindergartens for a total of 98,139 students. The current sample size is 4,500 children, which represents only 5% of children entering school. VIIS will compute the immunization rate for all VIIS clients entering kindergarten (children who are 56-64 months of age).

Legislation also requires that all persons entering the 6th grade have received a dose of TDaP (if it has been over 5 years since the last dose of tetanus-containing vaccine). This immunization assessment is also part of the Annual

Survey by VDH. The same procedure is followed as was used for the KGs.

It is estimated that VIIS will reduce approximately 1,560 hours of staff time per year saving VDH approximately $41,000 annually. In addition, VIIF is expected to greatly increase the accuracy of the KG survey by enlarging the sample size.

Contacting previous providers for immunization records by VDH staff. Currently webVISION[14], allows for the entry of both active vaccines given to a client at VDH and historical vaccines received in the past, and listed on an immunization shot record. Often the parent has lost the record or does not bring it to VDH, and the VDH staff must contact the private providers for additional vaccine history. In 2007, VDH conducted a survey of each local health district and learned that on the average, it spent 30 minutes contacting a past provider. In 2008, there were 81,159 unduplicated clients less than 19 years of age who received immunization services.[15] Assuming that the hourly rate of the immunization nurse is $25/hour, it costs $12.50 per incomplete record. Also assuming that 5% or 4,058 clients have incomplete immunization records requiring the nurse to contact the past provider, the cost savings in using VIIS (which provides complete immunization information from both the private and public health sectors) is $50,724.

Generating recall list. One of the most important public health functions at VDH is the ability to generate a Recall List to identify children who are due for immunizations or are not up-to-date with their age-appropriate immunizations. This allows the health department to notify the parents of these children to make an appointment to receive the necessary vaccines.

A 2002 study from Boston found that performing this task manually cost $7,520 for 5,333 children seen at 13 sites within the city and approximated that three minutes of staff time were necessary to identify children who were not up-to-date. In contrast, they found that their immunization information system could generate this list of all children who were not up-to-date at a cost of only $0.49. Historically at VDH, 40% of clients are not up-to-date and need to be recalled to receive vaccines. Again using the webVISION count of 81,159 unduplicated clients less than 19 years of age seen at VDH, 32,464 children needed to be recalled. This represents 3 minutes of staff time per child or approximately 2000 hours total. Using $25/hr. for staff, this is a cost savings of $40,580.

Elimination of vaccine waste. In 2008, the expired vaccine returned by the local Health Departments was valued at $57,889.53.[16] Although all of this wasted vaccine could not be eliminated by using VIIS for vaccine management, perhaps 50% could be transferred to other health districts to avoid wastage. Therefore, the cost savings to the state would be approximately $28,945. This figure does not include the shipping and handling cost for returning the vaccine.

Assessing immunization records of children entering public kindergarten. Currently, the Department of Education assesses the immunization status of all children entering kindergarten in the state (89,930 children in 2009). A study by All Kids Count[17] found that it costs approximately $14.50 for every record that is manually retrieved, reviewed, and re-filed and other studies show that it costs from $6 to almost $19 to manually pull a patient chart for review.[18] This represents a cost of $1,303,985. Another study by McKenna[6] found this cost to be $14.70 or an additional $17,986 to the state cost. Assessing an electronic record in VIIS takes seconds and the application prints out missing immunizations for that specific client at a cost of $0.49 according to her study. Although no figures have been reported dealing with the savings at the state level, it is estimated by CDC that $58 million would be saved on the national level by eliminating the manual pulling of records for all children entering kindergarten.[19] A 1999 study in Wisconsin[20] documented that 95 hours were spent by a county school system generating non-compliance letters to parents before the use of the IIS. In the fall of 2000 the schools linked to the local immunization registry, and reduced the 95 hour task to one hour. This reduction in staff time would represent an additional savings to the state.

Functionality in public health emergency. An article following Hurricane Katrina reported the successful use of two immunization information systems during a public health emergency.[21] Shortly after Katrina, the Houston-Harris County information system and the Louisiana information system were connected to look for missing immunization records for children in those areas. The linking of these two information system applications allowed for 18,900 immunization records to be found, representing an estimated cost savings of more than $1.6 million for vaccine alone and $3 million for vaccine plus administration fees. A CDC assessment of more than 21,000 records found, estimated that more than $4.6 million was saved in revaccination expenses.[22]

Businesses and Entities Affected. The users of VIIS include approximately 4,500 doctors within 1,700 sites that may be large or small medical practices, 200 Community Health Centers, Rural Health Clinics, and Federally Qualified Health Clinics, 5 mobile vans, 135 local health departments and clinics, 200 hospitals, 1,000 pharmacies providing immunizations, 4,000 schools, colleges, and universities, and 100 health care plans. Also, approximately 5 million Virginians are enrolled in VIIF.

Localities Particularly Affected. The proposed regulations apply throughout the Commonwealth.

Projected Impact on Employment. The operation and maintenance of VIIS is accomplished by three employees employed by a private contractor and 8.5 full time equivalent positions at VDH. Thus, VIIS raised the demand for labor in the Commonwealth. However, it is also estimated that VIIS has provided its users and VDH some staff time savings offsetting some of the increase in the demand for labor elsewhere.

Effects on the Use and Value of Private Property. VIIS is not anticipated to have a direct impact on the use and value of private property. However, it is expected to provide its users some savings and create additional demand for hardware, software, and supplies. The anticipated savings and demand for goods and services are expected to add to the asset values of private users and suppliers of goods and services.

Small Businesses: Costs and Other Effects. Of the affected entities, most of the doctors offices, private clinics, and pharmacies are believed to be small businesses. The costs and other effects of VIIS on small businesses are the same as the ones discussed above for all users. Since participation is voluntary, the costs and other effects may be avoided if desired.

Small Businesses: Alternative Method that Minimizes Adverse Impact. There is no alternative method that minimizes adverse impact on small businesses while accomplishing the same goals. Since participation is voluntary, the costs and other effects may be avoided if desired.

Real Estate Development Costs. No real estate development costs are expected.

Legal Mandate. The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007.04 of the Administrative Process Act and Executive Order Number 107 (09). Section 2.2-4007.04 requires that such economic impact analyses include, but need not be limited to, the projected number of businesses or other entities to whom the regulation would apply, the identity of any localities and types of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or entities to implement or comply with the regulation, and the impact on the use and value of private property. Further, if the proposed regulation has adverse effect on small businesses, § 2.2-4007.04 requires that such economic impact analyses include (i) an identification and estimate of the number of small businesses subject to the regulation; (ii) the projected reporting, recordkeeping, and other administrative costs required for small businesses to comply with the regulation, including the type of professional skills necessary for preparing required reports and other documents; (iii) a statement of the probable effect of the regulation on affected small businesses; and (iv) a description of any less intrusive or less costly alternative methods of achieving the purpose of the regulation. The analysis presented above represents DPB's best estimate of these economic impacts.

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[1] According to VDH, 25 states are using the same system used in Virginia, and all of the remaining states have some type of immunization information system in place.

[2] VDH believes that physician offices participating are eligible to receive up to $120,000 in federal grants.

[3] Horne PR, Saarlas KN, Hinman AR. Costs of immunization registries: experiences from the All Kids Count II projects. Am J Prev Med 2000; 19:94-8.

[4] Horne PR et al. An All Kids Count cost study on immunization registries. Paper presented at the All Kids Count Immunization Registry Conference; 1999 Apr 27-29; St. Paul, MN.

[5] Fairbrother G et al. It is Time! Accelerating the use of child health information systems to improve child health. Pediatrics. January 2009; 123 (2): S61-S63.

[6] Linkins RW. Immunization Registries: Progress and Challenges in Reaching the 2010 National Objective. J Public Health Management Practice. 2001; 7 (6): 67-74.

[7] Committee on Practice and Ambulatory Medicine Policy Statement: Immunization Information Systems. Pediatrics. September 2006; 118 (3): 1293-1294.

[8] National Vaccine Advisory Committee. Immunization Registries Progress Report. December 4, 2000. Washington, DC; 1-11.

[9] All Kids Count, Immunization Registries: Improving Health and Health Care, Internet Data.

[10] Feikema SM et al. Extra immunization among US children. JAMA. 2000; 283:1311-1317.

[11] Urquhart G, CDC/CCIS/NCIRD. Personal communication.

[12] These vaccines are Hepatitis B, MCV4, MMR, Pneumococcus, TdaP, Td, Varicella, and HPV.

[13] Bartlett DL et al. Cost Savings Associated with Using Immunization Information Systems for Vaccines for Children Administrative Tasks. J Public Health Management Practice. Nov-Dec 2007; 13(6): 559-66.

[14] WebVISION immunization data is uploaded into VIIS from VDH Public Health Information System.

[15] WebVISION data from 2007, VDH Public Health Information System.

[16] VDH Communication with Virginia Vaccine For Children program manager.

[17] All Kids Count Newsletter. Focus on Immunization Registries, Winter 2000.

[18] All Kids Count: Registries Save Time and Money.

[19] Horne PR et al. Update on Immunization Registries. Amer J Prev Med. 2001; 20:174.

[20] June 2006 Newsletter of the National Association of School Nurses.

[21] Boom JA et al. The Success of an Immunization Information System in the Wake of Hurricane Katrina. Pediatrics. 2007; 19 (6): 1213-1217.

[22] Urquhart G. Current Status of Immunization Information Systems in the U.S. Presentation at CDC Immunization Program Managers Meeting, November 2008; New Orleans, LA.

Agency's Response to Economic Impact Analysis: The agency concurs with the results of the Department of Planning and Budget's economic analysis of the Virginia Immunization Information System (12VAC5-115).

Summary:

The proposed regulations implement the Virginia Immunization Information System (VIIS). VIIS is a

voluntary, statewide immunization registry that consolidates patient immunization histories from birth to death into a complete, accurate, and definitive record that is available to Virginia's participating health care providers. The proposed regulations (i) define who is allowed access to VIIS; (ii) specify access requirement; (iii) ensure compatibility with current state and federal guidelines in the areas of patient data confidentiality and system security; (iv) address the security features of the application; (v) define the data to be collected; (vi) state the mechanisms for populating and capturing data; (vii) define the approved use of data, the authorized recipients, and the procedure for obtaining the data; and (viii) address the use of VIIS in a public health emergency.

CHAPTER 115

VIRGINIA IMMUNIZATION INFORMATION SYSTEM

12VAC5-115-10. Definitions.

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

"Commissioner" means the State Health Commissioner or his designee.

"Data exchange" means electronically sending immunization information from an existing information system to VIIS and being able to retrieve information from VIIS.

"De-duplication" means the process in information systems that matches incoming data with existing client records and merges those identified as the same client.

"Health care entity" means any health care provider, health plan, or health care clearinghouse.

"Health care provider" means those entities listed in § 8.01-581.1 of the Code of Virginia, except that state-operated facilities shall also be considered health care providers for the purposes of this section. Health care provider shall also include all persons who are licensed, certified, registered, or permitted or who hold a multistate licensure privilege issued by any of the health regulatory boards within the Department of Health Professions, except persons regulated by the Board of Funeral Directors and Embalmers or the Board of Veterinary Medicine.

"Health plan" means an individual or group plan that provides or pays the cost of medical care and shall include any entity included in such definition as set out in 45 CFR 160.103.

"Participant" means a person or organization with a VIIS account.

"Patient" means the client who is receiving health services or his parent or guardian.

"Public health emergency" means any (i) public health event caused by an act of bio-terrorism or vaccine-preventable disease outbreak or (ii) other public health event resulting from natural or human cause.

"Security role" means the level of security assigned to a participant that determines what information the individual may access in the application and what system functions may be performed.

"VDH" or "Department of Health" means the Division of Immunization within the Virginia Department of Health.

"Virginia Immunization Information System" or "VIIS" means the statewide immunization registry.

"VITA" means the Virginia Information Technologies Agency.

12VAC5-115-20. Authorized participants.

A. Health care providers, including but not necessarily limited to any physician, physician assistant, nurse practitioner, registered nurse, school nurse, pharmacist, or any entity listed in the definition of "health care provider" in § 8.01-581.1 of the Code of Virginia, are authorized to participate in VIIS.

B. Any health care entity may participate as long as it is licensed or certified in Virginia to deliver or support health care services or public health, requires immunization data to perform the health service function, and uses VIIS only for exchanging information on persons for whom it provides services.

C. Other state or regional immunization registries may exchange data with VIIS. They may share data and have access to data by contacting the VIIS program manager and complying with the registration procedure discussed in 12VAC5-115-30.

D. VDH shall give access to VIIS under the condition that having access to immunization information is required to perform the job function of the participant. The VIIS program manager or designee shall assign the security role of the participant based on his needs and job responsibilities.

E. Access to VIIS requires only Internet access and is free to participants.

12VAC5-115-30. Registration procedures.

A. Participation in VIIS is voluntary.

B. Completed registration forms from authorized participants must be processed and approved by VDH before access to the system is allowed. Registration will require the participant to assure compliance with necessary confidentiality and security access provisions that specify security procedures to ensure that VIIS data are protected from unauthorized view and access. The participant shall update and submit the forms to VDH every year.

C. Once the participant is approved, VDH will provide training and activate the participant in the VIIS system.

D. Qualifying participant organizations shall designate an administrator for their organization. The administrator may then allow VIIS access by an employee in his organization and, in doing so, shall assume responsibility for registering that person, obtaining the most recent security forms that

specify VITA or VDH security requirements, retaining all completed user forms, assigning the security role of the user, accepting legal responsibility for his proper use of VIIS, and terminating access to VIIS if the employee is noncompliant with VIIS requirements or no longer requires access.

E. An administrator may terminate his organization's participation at any time by notifying VDH in writing. All data entered by that organization shall remain in the system.

12VAC5-115-40. Patient confidentiality.

A. Access to VIIS information is authorized only under the condition that access to individual immunization information is required to perform the participant's job function.

B. Participants shall not conduct any activity that jeopardizes the proper function or security of VIIS. They shall use patient data only as authorized by law and this chapter and must immediately notify the patient and VDH of any breach of personal privacy or confidentiality.

C. Patients shall have the opportunity to opt-out of VIIS by doing one of the following:

1. Contacting their healthcare provider to allow the viewing of their immunizations only by that provider who administered them; or

2. Contacting VDH in writing requesting to be taken out of VIIS and have their record no longer viewable.

D. Patient immunization records shall not be copied except for authorized use. These copies shall not be left where they are visible by unauthorized personnel and shall be shredded before disposal.

E. VIIS records shall be treated with the same confidentiality and privacy as any other patient record. Any inappropriate use of VIIS records shall result in immediate suspension of participant privileges and an investigation conducted by VDH. Additional actions may be taken pursuant to § 32.1-27 of the Code of Virginia. The VIIS program manager may reinstate privileges.

F. Nothing in this chapter alters the provision in 45 CFR Part 164 that permits covered healthcare entities to disclose protected health information to a public health authority without individual authorization.

12VAC5-115-50. Security.

A. After VDH gives access to a VIIS participant, a secure connection is established between his browser and VIIS. The system is password protected.

B. Participants must ensure that employees with authorized access do not disclose their user identification code or password to anyone, have physical security and password-enabled screen savers on computers accessing VIIS, make every effort to protect VIIS screens from unauthorized view, and log off the system whenever leaving the VIIS workstation.

C. The VIIS system, which is maintained on a secure website, automatically inactivates a user session after a predetermined period of inactivity. The inactivation period is determined by VITA security policy.

D. The VIIS system inactivates user accounts, denying access to the system when participants have not logged into the system after a predetermined period of time. This inactivation period is determined by VITA security policy. The administrator must reactivate the account.

E. There shall be a secure encrypted connection between VIIS and the participating organization sending or receiving data if data exchange is performed. The encryption process will be determined by VITA or VDH or both.

12VAC5-115-60. Population of VIIS.

A. The VDH Divisions of Immunization and Vital Records have an agreement to populate demographic information in VIIS with birth certificate data. Death certificate data are used to make the VIIS record no longer viewable. Data exchange shall be performed on a periodic basis, but at least monthly.

B. Each participant shall make every effort to ensure the accuracy of all immunization and demographic information and shall include enough identifying information to allow for de-duplication of clients.

C. Data shall be reported in VIIS either by online data entry or by data exchange of files from other information systems. The health care provider or the designated health plan billed for the immunization shall report. Reporting shall occur within seven days of vaccine administration for online data entry participants. For data exchange participants, reporting shall occur within seven days of receipt of the information.

D. Both demographic and immunization data shall be reported by the participant.

1. Patient demographic information shall include, but is not limited to, patient's name, date of birth, gender, telephone number, home address, birth place, and mother's maiden name. The social security number, if provided, is encrypted by the application, appears as asterisks, and does not print out on reports for that client. The application allows only exact matches when the social security number is used for search purposes.

2. Patient immunization information shall include, but is not limited to, the type of immunization administered using industry standards such as vaccine groups, Health Level 7 codes, or Current Procedural Terminology codes; date the immunization was administered; identity of the health care provider who administered the vaccine; manufacturer; trade name; lot number; and, if present, any contraindications or religious or medical exemptions.

E. Participants in data exchange shall provide an acceptable level of data quality, such as correct data fields, data accuracy, and enough information to correctly merge with existing clients. Upon initial data delivery, and periodically thereafter, data shall be reviewed to determine data quality. Any rejected records shall be resolved by the participant in a timely way. VDH may suspend system privileges and refer to

§ 32.1-27 of the Code of Virginia for additional action for any organization that submits inaccurate data.

F. If insufficient information is reported to allow de-duplication of clients, incoming data will be placed in a pending file and must be manually merged, if appropriate. All participants shall identify a contact to work with VDH on pending files.

G. VDH shall incorporate immunization data pursuant to subsection E of § 32.1-46 of the Code of Virginia into VIIS by data exchange from other immunization systems, patient care management billing systems, or information systems to the extent possible.

12VAC5-115-70. Release of VIIS data.

A. Specific patient data shall be disclosed to the extent required or permitted by state and federal law or regulations, after contacting VDH who will verify the source of the request.

B. Specific patient data may be disclosed to health care entities to the extent required or permitted by state and federal law or regulations. See § 32.1-127.1:03 of the Code of Virginia.

C. Patient data shall be erased when no longer needed or when the computer is being terminated due to the replacement of the computer or the resignation, retirement, or dismissal of the participant.

D. Aggregate data from which personal identifying data has been removed or redacted may be released for the purposes of statistical analysis, research, or reporting only after approval by VDH.

E. Any inappropriate use of VIIS data shall result in immediate suspension of user privileges and result in an investigation conducted by VDH. Additional actions may be taken in accordance with § 32.1-27 of the Code of Virginia. The VIIS program manager may reinstate privileges upon satisfactory completion of required remedial actions and guarantee of proper use of VIIS in the future.

12VAC5-115-80. Data access in public health emergency.

A. In the event of an epidemic or an outbreak of a vaccine-preventable disease or any disease of public health significance or threat, the commissioner may access VIIS in accordance with § 32.1-40 of the Code of Virginia by contacting the Division of Immunization. The commissioner may release VIIS data in accordance with § 32.1-41 of the Code of Virginia.

B. The commissioner may designate additional persons to view VIIS information during a public health emergency. VDH shall contact designated authorized users, provide instruction for those who are not current participants, and activate an account.

C. The commissioner, by notifying the Division of Immunization, may include public health emergency announcements and notices or guidelines on the main screen that may be viewed immediately by the VIIS participants.

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 from the agency contact or may be viewed at the Office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Richmond, Virginia 23219.

FORMS (12VAC5-115)

Administrator Information, VIISADM (eff. 10/12).

Electronic Data Exchange With VIIS (eff. 10/12).

Information Systems Security Access Agreement (eff. 10/12).

Organization Information, VIISORG (eff. 10/12).

VIIS Security Policy and User Confidentiality Agreement.

Memorandum of Agreement between Virginia Department of Health/Division of Immunization (VDH/DOI) and VIIS Organization Interested in Data Exchange (8/11).

Virginia Immunization Information System (VIIS Opt Out-In form).

VIIS User Acknowledgement Page.

VIIS User Signature Page.

VA.R. Doc. No. R09-1776; Filed October 23, 2012, 1:23 p.m.

BOARD OF MEDICAL ASSISTANCE SERVICES

Proposed Regulation

Title of Regulation: **12VAC30-120. Waivered Services (adding 12VAC30-120-1700 through 12VAC30-120-1770; repealing 12VAC30-120-70 through 12VAC30-120-120).**

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

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: January 18, 2013.

Agency Contact: Yvonne Goodman, R.N., Long Term Care Division, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 786-0503, FAX (804) 786-1680, or email yvonne.goodman@dmas.virginia.gov.

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

DMAS' Technology Assisted Waiver operates under the authority of § 1915 (c) of the Social Security Act and 42 CFR 435.17, 42 CFR 435.211, and 42 CFR 435.230 that permit the waiver of certain State Plan requirements (such as comparability of services and sufficiency of the amount, duration, and scope of services). These cited federal statutory and regulatory provisions permit the establishment of Medicaid waivers to afford the states with greater flexibility to devise different approaches, as alternatives to institutionalization, in the provision of long term care services. This waiver authority permits DMAS to target specific services to eligible individuals on the basis of their diagnoses.

This particular waiver provides Medicaid individuals, who require complex medical care and substantial and ongoing skilled nursing care, with numerous supportive services thereby enabling them to remain in their homes and communities at lower costs, as opposed to being institutionalized in nursing facilities or long stay hospitals. Pursuant to federal statute, the costs of these services in the community are prohibited from costing, in the aggregate for this federally authorized waiver, more than the comparable institutional costs.

Purpose: The waiver originally became effective in 1988 primarily for ventilator dependent children and was approved by CMS and funded by the General Assembly. In 1997, CMS approved the addition of adults to this waiver. The impetus for the inclusion of adults derived largely from the fact that children, who had been cared for for years through this waiver, were becoming too old for the waiver services and had no alternative other than institutional care for their required medical care. These regulatory changes are needed to assure that the ongoing changes in medical technology and industry practices continue to support the health, safety, and welfare of this waiver population. DMAS anticipates that these modifications and updates will allow for provider agencies and their staff and the waiver individuals, while complying with applicable federal requirements, to continue to participate in this important and vital waiver program.

The Technology Assisted Waiver is responsible for and provides direct care coordination currently for 315 individuals who require complicated healthcare because they are chronically ill or severely impaired and dependent on sophisticated technology to sustain their lives. This population includes 228 (73%) children and 87 (27%) adults. Of the pediatric population, 196 (85%) require a tracheostomy to sustain life and of this 196, 86 (37%) are also ventilator dependent. Of the adult population, 68 (78%) require a ventilator to sustain life. Some of the common diagnoses found for this waiver population are Amyotrophic Lateral Sclerosis (ALS), Respiratory Failure, and Cerebral Palsy.

Substance: The state regulations that are affected by this action are the Technology Assisted Waiver regulations located at 12VAC30-120-70 through 12VAC30-120-120, which are being repealed. New regulations are being promulgated at 12VAC30-120-1700 et seq.

All of DMAS waiver programs contained different definitions for the same or similar terms which caused unnecessary confusion among providers. The existing Technology Assisted Waiver regulations contain limited requirements for individual screenings and individual eligibility requirements in regard to preadmission screenings. There is a lack of clarification of the criteria for alternate institutional placement as it relates to the age of the individual seeking consideration for waiver enrollment.

The existing regulations contain the general requirements for providers of waiver services, but do not include personal care aide qualifications, training, or mandated provider oversight (i.e.: providers' responsibility for documentation and record maintenance, provision for criminal record and sex offender checks, restrictions from hiring persons convicted of barrier crimes, and the assurance of dignity and quality of life for waiver individuals).

The current regulations do not include waiver individual's rights and responsibilities, a statement of participants' choice of providers of services or protection from abuse, neglect, exploitation, or misappropriation of property. The current regulations also do not include current standards of practice for the plan of care and skilled private duty nursing services.

Currently, these regulations require the use of the DMAS-225 (previously DMAS 122) form by the local departments of social services to communicate to long-term care provider's relevant information about individuals' eligibility. Providers are also able to access the electronic Automated Response System (ARS) and MediCall to obtain information about waiver individual's eligibility periods, patient pay responsibilities, and whether they have full or limited Medicaid coverage.

In addition to proposing a new uniform format (across all waiver programs) for these regulations, changes are proposed as follows: (i) definitions are updated to include current industry standards; (ii) preadmission screenings will be updated to require the use of the same assessment tool (the Uniform Assessment Instrument) for all individuals seeking waiver services regardless of age; (iii) age specific assessment tools are incorporated into the revised regulations and serve as a guideline for determination of the number of skilled private duty nursing hours that can be authorized for waiver individuals; (iv) specialized care criteria are updated for final determination of waiver criteria; (v) clarification is provided for congregate private duty nursing; (vi) clarification is provided for the federal limitation of no more than 16 hours of skilled private duty nursing services in a 24-hour period of time and the make up of missed nursing shifts; (vii) the inclusion of transition services under Money Follows the Person (MFP) is provided; (viii) nursing supervisory assessment visits are clarified; (ix) the plan of care is

expanded to include required information elements, signatures, and timeframes; (x) annual eligibility re-determination and quality management reviews are provided for; (xi) individuals rights and responsibilities are included; (xii) protection of individuals from abuse, neglect, exploitation, or misappropriation of property is included; (xiii) providers' responsibilities for documentation and record maintenance are added; (xiv) provision is made for criminal record and sex offender checks; (xv) limitations are provided on providers hiring of persons who have been convicted of barrier crimes; (xvi) the assurance of dignity and quality of life for waiver individuals is included; and (xvii) the appeal for denial of coverage rights for waiver individual is updated.

DMAS is also proposing changes consistent with mandates in Chapter 874 of the 2010 Acts of Assembly Item (297 WW and YYY) and Chapter 785 as follows: (i) subsection WW requires the reduction of covered respite hours from 720 to 240; (ii) subsection YYY requires the reduction of the maximum coverage amount for assistive technology and environment modification services from $5,000 to $3,000; and (iii) termination of provider agreements in instances where the provider has pled guilty to felony charges. The changes mandated by WW and YYY are affected by action of Congress to extend the Commonwealth's Federal Medical Assistance Percentage (FMAP) (the federal matching portion of DMAS' budget) under the American Recovery and Reinvestment Act (P.L. 111-5). If Congress extends DMAS FMAP rate, then the changes in WW will not be enacted and changes in YYY will only take effect in the second year of the budget.

Issues: The advantages to waiver individuals of these changes are the provision of assistance with transitioning out of skilled nursing facilities or long-stay hospitals into community care arrangements. The advantage to providers will be the updating of program requirements that are more up to date (than have previously existed for this program) as compared to current industry standards. These regulations are also being formatted consistently with other waiver programs to assist providers who participate in more than one waiver. These regulations also propose more uniformity to aid providers to the definitions than have been previously used in Medicaid's several waiver programs.

The advantage to the agency will be the clarification of provider requirements that are expected to reduce exceptions encountered during provider reviews. Such exceptions can result in DMAS recovering expenditures that for small providers can represent substantial sums of moneys to be returned to the program. These recoveries also often result in lengthy and costly provider appeal actions.

Improved efficiencies in this waiver program will reduce administrative expenditures that are more cost effective for the citizens of the Commonwealth. There are no disadvantages to citizens or the Commonwealth in these proposed changes.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. Pursuant to Chapter 874 of the 2010 Acts of Assembly Items 297 WW and YYY, the proposed regulations will 1) reduce the maximum annual respite care hours from 360 to 240 and 2) contingent upon the federal legislative actions, reduce the maximum coverage amount for assistive technology and environmental modification services from $5,000 to $3,000. In addition, the proposed regulations will clarify the use of personal care aide services when private duty nursing hours cannot be staffed due to a shortage of licensed nurses. Finally, the proposed changes will alter the format of the regulations to achieve uniformity across all waiver programs and clarify numerous other requirements already existing in the regulations.

Result of Analysis. There is insufficient data to accurately compare the magnitude of the benefits versus the costs. Detailed analysis of the benefits and costs can be found in the next section.

Estimated Economic Impact. Pursuant to Chapter 874 of the 2010 Acts of Assembly Item 297 WW, the proposed regulations will reduce the maximum annual respite care hours available to the technology assisted waiver recipients from 360 to 240.[1] According to Department of Medical Assistance Services (DMAS), this change is estimated to reduce the total expenditures by $100,784 in Fiscal Year (FY) 2011 and $412,028 in FY 2012. One half of these expenditures are funded by the state and the remaining half funded by the federal government. While this proposed change will provide fiscal savings for the state and the federal government, the main effect will be on the recipients who are requiring more than 240 hours of respite care in a given year and their family members as they will not be provided this service once the 240 hours limit is reached. Also, respite care providers are expected to be negatively affected as the demand for their services will decrease. Finally, the reduction in the influx of monies from the federal government into the Commonwealth represents a leakage and is expected to have a contractionary effect on the economy.

Similarly, Chapter 874 of the 2010 Acts of Assembly Item 297 YYY mandates that DMAS decrease the annual amount paid for environmental modifications and assistive technology from $5,000 to $3,000 effective January 1, 2011 unless there is an extension through June 30, 2011 of the increased Federal Medical Assistance Percentage under the American Recovery and Reinvestment Act. If the increased federal funding is not extended, this change is expected to reduce the environmental modification and assistive technology expenditures by $41,764 in FY 2011 and $94,488 in FY 2012. One half of these expenditures would be funded by the state and the remaining half funded by the federal government. While this proposed change would provide fiscal savings for the state and the federal government, the main

effect would be on the recipients who would be requiring more than $3,000 in a given year for their assistive technology and environmental modification needs as they would not be provided these products and services once the $3,000 limit is reached. Also, providers of assistive technology and environmental modifications would be expected to be negatively affected as the demand for their products and services will decrease. Finally, the reduction in the influx of monies from the federal government into the state represents a leakage and would be expected to have a contractionary effect on the economy. At this time, no action has been taken to extend the increased federal funding for Medicaid.

Another proposed change will clarify the use of personal care aide services when private duty nursing hours cannot be staffed due to a shortage of licensed nurses which typically occurs in rural areas. According to DMAS, based upon current waiver enrollment, the primary caregiver assumes at least eight hours of skilled nursing care per day and, when skilled nursing hours cannot be staffed, 24 hours of care. Personal care aide hours are used in conjunction with waiver services and while personal care aide service utilization is currently underutilized, the proposed clarification have the potential to increase the amount of personal care aide hours that may be used in the future.

The remaining changes are reorganization of the regulations to achieve consistency across all of the waiver programs and clarifications of requirements that currently exist either in the regulations or in the Code of Virginia. While these changes are not expected to create a significant direct economic impact as they already exist, they are expected to reduce the exceptions encountered during provider review and reduce the number of incorrect reimbursements and consequently provide some administrative savings to DMAS and the providers.

Businesses and Entities Affected. Approximately 323 recipients are receiving services under this waiver. Also, there are approximately 1,500 durable medical equipment providers and about 30 assistive technology and environmental modification service providers.

Localities Particularly Affected. The proposed regulations apply throughout the Commonwealth.

Projected Impact on Employment. The proposed reduction in the number of respite care hours and reduction in the spending limit for the environmental modifications have the potential to reduce the demand for labor. The proposed clarification of personal care aide hours for enrollees in conjunction with skilled nursing care could increase the demand for personal care services. Finally, the other proposed clarifications may reduce the number of appeals involved with recoveries and reduce the demand for labor associated with the administrative services.

Effects on the Use and Value of Private Property. The proposed regulations are not expected to have a direct impact on the use and value of private property. However, the proposed reduction in the number of respite care hours and reduction in the spending limit for the environmental modifications have the potential to reduce the profits and consequently the asset values of the affected providers. On the other hand, the updating of personal care for enrollees in conjunction with skilled nursing services and reducing the number of appeals involved with recoveries by improving the clarity of the regulations could increase the profits and consequently the asset values of the affected providers.

Small Businesses: Costs and Other Effects. According to DMAS, most, if not all, of the 1,500 durable medical equipment providers and 30 assistive technology and environmental modification service providers are small businesses. The costs and other effects on small businesses are the same as the ones discussed above.

Small Businesses: Alternative Method that Minimizes Adverse Impact. There is no alternative method that minimizes the adverse impact while achieving the same goal.

Real Estate Development Costs. No significant effect on real estate development costs is expected.

Legal Mandate. The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007.04 of the Administrative Process Act and Executive Order Number 14 (10). Section 2.2-4007.04 requires that such economic impact analyses include, but need not be limited to, the projected number of businesses or other entities to whom the regulation would apply, the identity of any localities and types of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or entities to implement or comply with the regulation, and the impact on the use and value of private property. Further, if the proposed regulation has adverse effect on small businesses, § 2.2-4007.04 requires that such economic impact analyses include (i) an identification and estimate of the number of small businesses subject to the regulation; (ii) the projected reporting, recordkeeping, and other administrative costs required for small businesses to comply with the regulation, including the type of professional skills necessary for preparing required reports and other documents; (iii) a statement of the probable effect of the regulation on affected small businesses; and (iv) a description of any less intrusive or less costly alternative methods of achieving the purpose of the regulation. The analysis presented above represents DPB's best estimate of these economic impacts.

[1] Due to a drafting error, the Budget Bill references a reduction from 720 to 240 hours.

Agency's Response to Economic Impact Analysis: The agency concurs with the economic impact analysis prepared by the Department of Planning and Budget regarding the regulations concerning Technology Assisted Waiver.

Summary:

This action repeals the existing Technology Assisted Waiver regulations (12VAC30-120-70 through 12VAC30-120-120) and promulgates new regulations (12VAC30-120-1700 et seq.) in response to changes in the affected industry and to achieve greater consistency and clarity in content and format with the other Department of Medical Assistance (DMAS) waiver programs.

The proposed amendments (i) expand and modify definitions; (ii) update waiver participant eligibility requirements for clarification of institutional deeming rules and for consistency and clarity in the use of a Uniform Assessment Instrument for eligibility determination (the deeming rules are applied as if the participant resided in an institution and would require that level of care); (iii) update provider participation standards and staff qualifications for consistency with current industry standards; (iv) incorporate the use of the Uniform Assessment Instrument and screening guidelines for anyone requesting waiver screening; (v) clarify DMAS provision of direct waiver oversight for this waiver and authorization of services; (vi) update and clarify all waiver services and provider service delivery standards to the current industry standards; (vii) include and expand waiver participant rights and responsibilities; and (viii) update to current industry practices the waiver individual's right to file grievances or exercise appeal rights.

~~Part II~~

~~Home and Community Based Services for Technology Assisted Individuals~~

12VAC30-120-70. ~~Definitions~~. (Repealed.)

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

~~"Activities of daily living (ADL)" means personal care tasks, i.e., bathing, dressing, toileting, transferring, bowel/bladder control, and eating/feeding. A person's degree of independence in performing these activities is a part of determining appropriate level of care and services.~~

~~"Adult" means an individual who either is 21 years of age or is past 21 years of age.~~

~~"Assistive technology" means specialized medical equipment and supplies including those devices, controls, or appliances specified in the plan of care but not available under the State Plan for Medical Assistance that enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live, or that are necessary to the proper functioning of the specialized equipment.~~

~~"Child" means an individual who has not yet reached his 21st birthday.~~

~~"Congregate living arrangement" means one in which two or more recipients live in the same household and may share receipt of health care services from the same provider or providers.~~

~~"Congregate private duty nursing" means nursing provided to two or more recipients in a group setting.~~

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

~~"Environmental modifications" means physical adaptations to a house, or place of residence, which shall be necessary to ensure the individual's health or safety, or enable functioning with greater independence when the adaptation is not being used to bring a substandard dwelling up to minimum habitation standards and is of direct medical or remedial benefit to the individual. Such modifications must exceed reasonable accommodation requirements of the Americans with Disabilities Act (42 USC § 1201 et seq.).~~

~~"Health care coordination" means a comprehensive needs assessment, determination of cost effectiveness, and the coordination of the service efforts of multiple providers in order to avoid duplication of services and to ensure the individual's access to and receipt of needed services.~~

~~"Health care coordinator" means the registered nurse who is responsible for ensuring that the assessment, care planning, monitoring, and review activities as required by DMAS are accomplished. This individual may be either an employee of DMAS or a DMAS contractor.~~

~~"Instrumental activities of daily living (IADL)" means social tasks, i.e., meal preparation, shopping, housekeeping, laundry, money management. A person's degree of independence in performing these activities is a part of determining appropriate level of care and services. The provision of IADLs is limited to the individual receiving services and not to family members or other persons in the household. Meal preparation is planning, preparing, cooking and serving food. Shopping is getting to and from the store, obtaining/paying for groceries and carrying them home. Housekeeping is dusting, washing dishes, making beds, vacuuming, cleaning floors, and cleaning kitchen/bathroom. Laundry is washing/drying clothes. Money management is paying bills, writing checks, handling cash transactions, and making change.~~

~~"Medical equipment and supplies" means those articles prescribed by the attending physician, generally recognized by the medical community as serving a diagnostic or therapeutic purpose and as being a medically necessary element of the home care plan. Items covered are medically necessary equipment and supplies needed to assist the individual in the home environment, without regard to whether those items are covered by the Plan.~~

~~"Objective Scoring Criteria" means the evaluative tool to be used to determine the appropriateness for an individual's admission to these services.~~

~~"Personal assistance" means care provided by an aide or respiratory therapist trained in the provision of assistance with ADLs or IADLs.~~

~~"Personal emergency response systems" or "PERS" means an electronic device and monitoring service that enable certain individuals at high risk of institutionalization to secure help in an emergency. PERS services are limited to those individuals who live alone or are alone for significant parts of the day and who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision. 12VAC30-120-970 provides the service description, criteria, service units and limitations, and provider requirements for this service.~~

~~"Plan of care" means the written plan of services and supplies certified by the attending physician needed by the individual to ensure optimal health and safety for an extended period of time.~~

~~"Primary caregiver" means the primary person who consistently assumes the role of providing direct care and support of the individual to live successfully in the community without compensation for such care.~~

~~"Private duty nursing" means individual and continuous nursing care provided by a registered nurse or a licensed practical nurse under the supervision of a registered nurse.~~

~~"Providers" means those individuals or facilities registered, licensed, or certified, or both, as appropriate, and enrolled by DMAS to render services to Medicaid recipients eligible for services.~~

~~"Respite care services" means temporary skilled nursing services designed to relieve the family of the care of the technology assisted individual for a short period or periods of time (a maximum of 15 days per year or 360 hours per 12-month period). In a congregate living arrangement, this same limit shall apply per household. Respite care shall be provided in the home of the individual's family or caretaker.~~

~~"State Plan for Medical Assistance" or "the Plan" means the document containing the covered groups, covered services and their limitations, and provider reimbursement methodologies as provided for under Title XIX of the Social Security Act.~~

~~"Technology assisted" means any individual defined as chronically ill or severely impaired who needs both a medical device to compensate for the loss of a vital body function and substantial and ongoing skilled nursing care to avert death or further disability and whose illness or disability would, in the absence of services approved under this waiver, require admission to or prolonged stay in a hospital, nursing facility, or other medical long-term care facility.~~

~~"Transition services" means set-up expenses for individuals who are transitioning from an institution or licensed or certified provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his own living expenses. 12VAC30-120-2010 provides the service description, criteria, service units and limitations, and provider requirements for this service.~~

12VAC30-120-80. ~~General coverage and requirements for technology assisted waiver services.~~ (Repealed.)

~~A. Coverage statement.~~

~~1. Coverage shall be provided under the administration of DMAS for certain technology assisted individuals who would otherwise remain in hospitals (for individuals under 21) or specialized care nursing facilities (for those over 21) for which Medicaid reimbursement would be made.~~

~~2. The objective of this waiver is to provide for medically appropriate and cost effective coverage of services necessary to maintain these individuals in the community.~~

~~3. Coverage shall not be provided for these services for individuals who reside in board and care facilities or adult care residences nor who are inpatients in general acute care hospitals, skilled or intermediate nursing facilities, or intermediate care facilities for the mentally retarded.~~

~~B. Patient qualifications. A Medicaid eligible technology assisted individual shall be eligible for services if he meets the following requirements:~~

~~1. The technology assisted individual who is younger than 21 years of age shall be determined to need a medical device when the individual meets one or more of the following categories:~~

~~a. Individuals depending at least part of each day on mechanical ventilators.~~

~~b. Individuals requiring prolonged intravenous administration of nutritional substances or drugs or ongoing peritoneal dialysis.~~

~~c. Individuals having daily dependence on other device-based respiratory or nutritional support, including tracheostomy tube care, oxygen support, or tube feeding.~~

~~2. The technology assisted individual who is 21 years of age or older shall be determined to need a medical device when the individual meets one or more of the following categories:~~

~~a. Individuals depending at least part of each day on mechanical ventilators.~~

~~b. Individuals requiring prolonged intravenous administration of nutritional substances or drugs or ongoing peritoneal dialysis.~~

~~3. The individual's attending physician must certify the individual's need for this level of care which must include the need for private duty nursing.~~

~~4. In addition to the medical needs identified in subdivision 1 or 2 of this subsection, the technology assisted individual shall be determined to need substantial and ongoing skilled nursing care. This determination shall be made using an objective tool approved by DMAS. The recipient shall be required to meet a minimum standard on the Objective~~

~~Scoring Criteria to be eligible to be admitted to technology assisted waiver services.~~

~~5. In addition to the medical needs identified in subdivision 1 or 2 of this subsection, Medicaid eligible individuals younger than 21 shall be admitted to this service only if the anticipated cost to Medicaid of home care will be less than or equal to the cost to Medicaid of the individual in a hospital or nursing facility.~~

~~6. In addition to the medical needs identified in subdivision 1 or 2 of this subsection, an individual older than 21 shall be admitted to this waiver service only if the anticipated cost to Medicaid of his home care will be less than or equal to the current average cost of care in a specialized nursing facility.~~

~~7. Adult Medicaid eligible individuals who entered this waiver service prior to their 21st birthday shall be required to conform to the same medical needs and individual cost-effectiveness standards as specified for all other adults.~~

~~8. If a person is over age 21 and already a waiver recipient and requires admission to a nursing facility or rehabilitation hospital for more than 30 days, the recipient will be discharged from the waiver. To be readmitted to the waiver services, the recipient must be assessed to determine that the recipient currently meets the specialized nursing facility and waiver criteria. If these criteria are met, the recipient shall be readmitted to waiver services.~~

~~9. The individual shall have a primary caregiver who accepts responsibility for the individual's health and welfare. The primary caregiver shall be responsible for a minimum of eight hours of the individual's care in a 24-hour period.~~

~~10. Individuals over the age of 21 years may live in congregate living arrangements and shall have primary caregivers. Two such individuals may share the time and services of one caregiver who shall provide a minimum of eight hours of care in a 24-hour time period.~~

~~11. These services shall not be available to individuals while an inpatient in general acute care hospitals, skilled nursing facilities, intermediate care facilities, intermediate care facilities for the mentally retarded, board and care facilities, or adult care residences.~~

~~12. Any individual, regardless of age, who requires admission to any type of medical care facility for fewer than 30 days shall again be eligible for waiver services upon discharge from the facility so long as all other requirements continue to be met.~~

~~C. Patient eligibility requirements.~~

~~1. Individuals receiving services under this waiver must be eligible under one of the following eligibility groups: ADC and AFDC related recipients, SSI and SSI related recipients, aged, blind or disabled recipients eligible under 42 CFR 435.121, and the special home and community-based waiver group at 42 CFR 435.217 which includes individuals who are eligible under the State Plan if they were institutionalized. The income level used for the special home and community based waiver group at 42 CFR 435.217 is 300% of the current Supplemental Security Income payment standard for one person. Medically needy individuals are eligible if they meet the medically needy financial requirements for income and resources.~~

~~2. Under this waivered service, the coverage groups authorized under § 1902(a)(10)(C)(i)(III) of the Social Security Act (42 USC § 1396a(a)(10)) will be considered as if they were institutionalized for the purpose of applying institutional deeming rules. All recipients under the waiver must meet the financial and nonfinancial Medicaid eligibility criteria and be Medicaid eligible in an institution. The deeming rules are applied to waiver eligible individuals as if the individuals were residing in an institution or would require that level of care.~~

~~3. Virginia shall reduce its payment for home and community based services provided for an individual by that amount of the individual's total income (including amounts disregarded in determining eligibility) that remains after allowable deductions for personal maintenance needs, deductions for other dependents and medical needs have been made according to the requirements in 42 CFR 435.726. Such specified reductions shall be made as specified in 42 CFR 435.726 in the specified order from the individual's income.~~

~~4. Individuals who are eligible for third party payment for the alternative institutional services shall not be eligible for these waivered services. If an individual or an individual's legally responsible party voluntarily cancels any insurance plan which would have provided coverage for institutional services in order to become eligible for waiver services within one year prior to the date waiver services are requested, eligibility for the waiver shall be denied.~~

12VAC30-120-90. ~~Covered services and provider requirements.~~ (Repealed.)

~~A. Private duty nursing service shall be covered for individuals enrolled in the technology assisted waiver services. This service shall be provided through either a home health agency licensed or certified by the Virginia Department of Health for Medicaid participation and with which DMAS has a contract for private duty nursing or a day care center licensed by the Virginia Department of Social Services which employs registered nurses and is enrolled by DMAS to provide congregate private duty nursing. At a minimum, the private duty nurse shall either be a licensed practical nurse or a registered nurse with a current and valid license issued by the Virginia State Board of Nursing.~~

~~1. For individuals under 21 whether living separately or congregately, during the first 30 days after the individual's admission to the waiver service, private duty nursing is covered for 24 hours per day if needed and appropriate to~~

assist the family in adjustment to the care associated with technology assistance. After 30 days, private duty nursing shall be reimbursed for a maximum of 16 hours per 24-hour period per household. The department may grant individual exceptions, not to exceed 30 total days per annum, to these maximum limits based on documented emergency needs of the individual and the case, which continue to meet requirements for cost effectiveness of community services. Such consideration of documented emergency needs shall not include applicable additional emergency costs.

2. For individuals over the age of 21 years whether living separately or congregately, private duty nursing shall be reimbursed for a maximum of 16 hours within a 24 hour period per household provided that the cost effectiveness standard is not exceeded for the individual's care.

3. In no instance, shall DMAS approve an ongoing plan of care or ongoing multiple plans of care per household which result in approval of more than 16 hours of private duty nursing in a 24 hour period per household.

4. Individuals who no longer meet the patient qualifications for either children or adults cited in 12VAC30-120-80 may be eligible for private duty nursing for the number of hours per 24 hour period previously approved in the plan of care not to exceed two weeks from the date the attending physician certifies the cessation of daily technology assistance.

5. The hours of private duty nursing approved for coverage shall be limited by either medical necessity or cost effectiveness or both.

6. Congregate private duty nursing shall be limited to a maximum ratio of one private duty nurse to two waiver recipients. When three or more waiver recipients share a home, ratios will be determined by the combined needs of the residents.

B. Provided that the cost-effectiveness standard shall not be exceeded, respite care service shall be covered for a maximum of 360 hours within a calendar year per household for individuals who are qualified for technology assisted waiver services and who have a primary caregiver, other than the provider, who requires relief from the burden of caregiving. This service shall be provided by skilled nursing staff (registered nurse or licensed practical nurse licensed to practice in the Commonwealth) under the direct supervision of a home health agency licensed or certified by the Virginia Department of Health for Medicaid participation and with which DMAS has a contract to provide private duty nursing.

C. Provided that the cost-effectiveness standard shall not be exceeded, durable medical equipment and supplies shall be provided for individuals qualified for technology services. All durable medical equipment and supplies, including nutritional supplements, which are covered under the State Plan and those medical equipment and supplies, including such items which may be defined as assistive technology and environmental modifications which are not covered under the State Plan but are medically necessary and cost effective for the individual's maintenance in the community, shall be covered. This service shall be provided by persons qualified to render it. Durable medical equipment and supplies shall be necessary to maintain the individual in the home environment.

1. Medical equipment and supplies shall be prescribed by the attending physician and included in the plan of care, and must be generally recognized as serving a diagnostic or therapeutic purpose and being medically necessary for the home care of the individual.

2. Vendors of durable medical equipment and supplies related to the technology upon which the individual is dependent shall have a contract with DMAS to provide services.

3. In addition to providing the ventilator or other respiratory deviced support and associated equipment and supplies, the vendor providing the ventilator shall ensure the following:

a. 24 hour on call for emergency services;

b. Technicians to make regularly scheduled maintenance visits at least every 30 days and more often if called;

c. Replacement or repair of equipment and supplies as required; and

d. Respiratory therapist registered or certified with the National Board for Respiratory Care (NBRC) on call 24 hours per day and stationed within two hours of the individual's home to facilitate immediate response. The respiratory therapist shall be available for routine respiratory therapy as well as emergency care. In the event that the Department of Health Professions implements through state law a regulation requiring registration, certification or licensure for respiratory therapists to practice in the Commonwealth, DMAS shall require all respiratory therapists providing services to this technology assisted population to be duly registered, licensed or certified.

D. Provided that the cost effectiveness standard shall not be exceeded, personal assistance services shall be covered for individuals over the age of 21 who require some assistance with activities of daily living and instrumental activities of daily living but do not require and are able to do without skilled interventions during portions of their day or are able to self perform a portion of their ADLs or IADLs or direct their skilled care needs during the period when personal assistance would be provided. Personal assistance services shall be rendered by a provider who has a DMAS provider agreement to provide personal care, home health care, and private duty nursing. At a minimum, the staff providing personal assistance must have been certified through coursework as either personal care aides, home health aides, homemakers,

personal care attendants, or registered or certified respiratory therapists.

E. Assistive technology services shall be covered for individuals enrolled in the technology assisted waiver. 12VAC30-120-762 provides the service description, criteria, service units and limitations, and provider requirements for this service.

F. Environmental modifications services shall be covered for individuals enrolled in the technology assisted waiver. 12VAC30-120-758 provides the service description, criteria, service units and limitations, and provider requirements for this service.

G. Transition services shall be covered for individuals enrolled in the technology assisted waiver. 12VAC30-120-2010 provides the service description, criteria, service units and limitations, and provider requirements for this service.

12VAC30-120-100. ~~Provider reimbursement.~~ (Repealed.)

A. All private duty nursing services shall be reimbursed at an hourly negotiated fee.

B. Respite care shall be reimbursed at an hourly negotiated fee.

C. Prior approval for durable medical equipment and supplies shall be requested from DMAS by the durable medical equipment provider. Prior approval by DMAS shall be required for all durable medical equipment and other medically related supplies furnished under this program before the individual's admission to waiver services and before reimbursement. If additional equipment and supplies are needed following the individual's admission to waiver services, the durable medical equipment provider must obtain DMAS' prior approval. This prior authorization requirement shall apply to all durable medical equipment and supplies that are covered under the State Plan or the waiver.

D. Personal assistance shall be reimbursed at an hourly negotiated fee.

E. Effective July 1, 2008, agency-directed individual supported employment rates shall be paid at the same provider-specific rates paid by the Department of Rehabilitative Services.

12VAC30-120-110. ~~Assessment and plan of care requirements.~~ (Repealed.)

A. The attending physician and a health care coordinator must participate in the approval of the initial assessment and the number of hours of nursing service required.

1. The physician shall be currently certified by the Board of Medicine and have a currently valid license to practice medicine in the Commonwealth. The physician shall have experience in the needs and care of technology assisted persons and the needs of children if the individual being admitted to waiver services is a child.

2. The health care coordinator must be currently and validly licensed to practice nursing in the Commonwealth. The nurse shall have experience in the needs and care of technology assisted persons and the needs of children if the individual being admitted to waiver services is a child.

3. Other specialists who are currently and validly licensed, registered or certified to practice their specialities within the Commonwealth may participate in the assessment and care planning process. These other specialists shall have experience in the needs and care of technology assisted persons and the needs of children if the person being admitted to waiver services is a child.

4. The health care coordinator shall be responsible for ensuring that the assessment, care planning, monitoring, and review activities required by DMAS are accomplished and documented consistent with DMAS' requirements. For individuals over the age of 21, the health care coordinator must determine that the minimum established nursing facility criteria are met.

B. Referral for waiver services and assessment.

1. For individuals under age 21, a service referral may originate from either the clinical staff in the hospital where the individual is located or from a health care professional in the community where the individual is receiving non-Medicaid funded home and community based services. For individuals over age 21, the referral may originate from the discharge planning staff in the nursing facility where the individual resides or from persons in the community who are aware of the needs of the individual.

2. The health care coordinator shall first determine that Medicaid would be the source of payment for the individual's institutional care if waiver services are not available. An individual for whom third party payment is available for the alternative institutional care is not eligible for the waiver service nor is an individual whose insurance has been voluntarily dropped in anticipation of waiver application and an assessment for waiver services is not to be completed.

3. Upon receiving consent from the legally competent recipient or the recipient's legal guardian or the parent of a minor child to explore the possibility of home care, the health care coordinator shall arrange for the assessment process for waiver services. The attending physician and a health care coordinator must participate in the approval of the initial assessment and the number of hours of nursing service required.

4. At the time of assessment, certification from the attending physician that the individual would otherwise require continued acute care or specialized nursing facility care shall be necessary to continue the assessment process.

5. Upon the completion of the assessment process the health care coordinator shall make a determination of the need for substantial and ongoing skilled nursing care. This determination will be made using an objective tool approved by DMAS. For admission to or continuation in

~~the technology assisted waiver program, the recipient will be required to meet a score of 50 or more on the Objective Scoring Criteria form.~~

~~C. Development of the plan of care.~~

~~1. Upon completion of the required assessments and a determination that the individual needs substantial and ongoing skilled nursing care, the hours of nursing service required is developed and approved by the health care coordinator.~~

~~2. At minimum, the plan of care shall include:~~

~~a. A statement of the appropriateness of the home in which the individual is to be placed.~~

~~b. Identification of the type, frequency, and amount of nursing care and personal assistance needed. This shall include the name of the provider agency, whether the nurse is an RN or an LPN, and verification that the nurse is licensed to practice in the Commonwealth and the professional qualifications of the personnel required to provide personal assistance. This shall also contain documentation that the health care coordinator has verified that the provider agency is an enrolled provider with DMAS to provide the appropriate waiver services for the individual.~~

~~c. Identification of all other services that are needed for the individual to be maintained in the home. The statement shall include, as appropriate, speech therapy, occupational therapy, physical therapy, transportation, physician services, the frequency and amount of service needed, the provider of the service, and the payment source.~~

~~d. A complete list of equipment and supply needs, and identification of the provider and source of payment.~~

~~e. Identification of the type, frequency, and amount of care that the family or other informal care givers shall provide.~~

~~f. Other referrals for assessment for services (as needed and appropriate) to include but not be limited to the school system; Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); child development clinic services; and Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) services.~~

~~g. Identification of the primary care physician in the community who has agreed to manage the medical care of the individual in the community.~~

~~h. The appropriateness of the medical care, including a statement from the individual's primary care physician, to be signed by the legally responsible adult, attesting that the medical care the individual is to receive in the home is agreed to by the legally responsible adult and all others involved in the assessment process referred to in this section.~~

~~D. Cost effectiveness computations.~~

~~1. Cost effectiveness computations shall be completed by the health care coordinator upon completion of the plan of care for any individual entering the waiver.~~

~~2. For individuals over 21, the health care coordinator shall be required to document the anticipated cost to DMAS for the individual's waiver services for a 12 month period. The health care coordinator shall then compare DMAS' costs for the waiver to the average costs to DMAS for specialized nursing facility care for the individual.~~

~~3. For individuals under 21, the health care coordinator shall be required to document the anticipated cost to DMAS for the individual's waiver services for a 12 month period. The health care coordinator shall then compare DMAS' costs for the waiver to the average costs to DMAS for continued hospitalization of the individual.~~

~~E. Patient selection of waiver services.~~

~~1. The health care coordinator shall give the legally competent recipient or the recipient's legal guardian or the parent of a minor child the choice of waiver services or institutionalization.~~

~~2. If waiver services are chosen, the applicant or his legally responsible adult will also be given the opportunity to choose the providers of service, if more than one provider is available to render the services. If more than one waiver recipient will reside in the home, one waiver provider shall be chosen to provide all private duty nursing services for all waiver recipients in the home. Only one nurse will be authorized to care for each two waiver recipients in a home. In the instance when more than two waiver participants share a home, nursing ratios will be determined by the health care coordinator based on the needs of all the recipients living together.~~

~~F. DMAS shall review and approve the assessment, plan of care, cost effectiveness, and choice of providers prior to the individual's admission to community waiver services, and prior to Medicaid payment for any services related to the waiver plan of care.~~

12VAC30-120-115. ~~Reevaluation requirements and utilization review.~~ (Repealed.)

~~A. The need for reevaluations shall be determined by the health care coordinator. Reevaluations shall be conducted by the health care coordinator as required by the individual's needs and situation and at any time when a change in the individual's condition indicates the need for reevaluation.~~

~~B. DMAS is responsible for performing utilization review at least every six months and for the maintenance of supporting documentation. DMAS shall maintain a copy of the plan of care, the initial evaluation, and each reevaluation for the minimum period required by federal and state law.~~

~~C. The health care coordinator shall review the plan of care for appropriateness of the level, amount, type, and quality of~~

~~services provided as well as for monitoring the cost effectiveness of the individual's care in the community.~~

~~D. Medical necessity of waiver services shall be reviewed by the health care coordinator and DMAS.~~

~~E. If the health care coordinator or DMAS determines, during utilization review or at any other time, that the waiver individual no longer meets cost-effectiveness standards or medical needs criteria, then the health care coordinator or DMAS, as appropriate, shall deny payment for such waiver individual with the exception of a child or adult who no longer meets the patient qualifications of 12VAC30-120-80 who may be eligible for private duty nursing for the number of hours previously approved in the plan of care per 24-hour period not to exceed two weeks from the date the attending physician certifies the cessation of daily technology assistance.~~

12VAC30-120-120. ~~Appeal of denied coverage.~~ (Repealed.)

~~A. DMAS shall provide the opportunity for a fair hearing under 42 CFR Part 431, Subpart E, to individuals who are not given the choice of home and community-based services as an alternative to receiving hospital or nursing facility services or who are denied the amount or type of service of their choice or the provider of their choice. Persons who are discharged from waiver services shall also have the right to file an appeal.~~

~~B. The individual shall be advised in writing of the denial and of his right to appeal consistent with DMAS client appeals (12VAC30-110-10 through 12VAC30-110-600).~~

Part IX
Home and Community-Based Services for Technology Assisted Individuals

12VAC30-120-1700. Definitions.

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

"Abuse" means the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, sexual abuse, or exploitation of a waiver individual. Types of abuse include: (i) physical abuse (a physical act by a person that may cause physical injury to an individual); (ii) psychological abuse (an act, other than verbal, that may inflict emotional harm, invoke fear or humiliate, intimidate, degrade, or demean an individual); (iii) sexual abuse (an act or attempted act such as rape, incest, sexual molestation, sexual exploitation, sexual harassment, or inappropriate or unwanted touching of an individual); and (iv) verbal abuse (using words to threaten, coerce, intimidate, degrade, demean, harass, or humiliate an individual).

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

"Adult" means an individual who is either 21 years of age or older.

"Adult foster care" means room and board, supervision, and a locally optional program that may be provided by a single provider for up to three adults who has or have a physical or mental condition. The provider must be approved by the local department of social services for the locality in which the provider renders services.

"Adult Protective Services" or "APS" means a program overseen by the Virginia Department of Social Services that investigates reports of abuse, neglect, and exploitation of adults aged 60 and over and incapacitated adults over 18 years of age and provides services when such persons are found to be in need of protective services.

"Agency provider" means a public or private organization or entity that holds a Medicaid provider agreement and furnishes services to individuals using its own employees or subcontractors.

"Alternate back up facility" means the alternate facility placement that the technology assisted individuals must use when home and community-based waiver services are interrupted. Such facilities may be, for the purpose of this waiver, an intermediate care facility for the mentally retarded (ICF/MR), a long-stay hospital, a specialized care nursing facility, or an acute care hospital when all technology assisted waiver criteria are met.

"Americans with Disabilities Act" or "ADA" means the United States Code pursuant to 42 USC § 12101 et seq., as amended.

"Appeal" means the process used to challenge actions regarding services, benefits, and reimbursement provided by Medicaid pursuant to 12VAC30-110 and Part XII (12VAC30-20-500 et seq.) of 12VAC30-20.

"Applicant" means an individual (or representative on his behalf) who has applied for or is in the process of applying for and is awaiting a determination of eligibility for admission to the technology assisted waiver.

"Assess" means to evaluate an applicant's or an individual's condition, including functional status, current medical status, psychosocial history, and environment. Information is collected from the applicant or individual, applicant's or individual's representative, family, and medical professionals, as well as the assessor's observation of the applicant or individual

"Assessment" means one or more processes that are used to obtain information about an applicant, including his condition, personal goals and preferences, functional limitations, health status, financial status and other factors that are relevant to the determination of eligibility for services and is required for the authorization of and provision of

services, and forms the basis for the development of the plan of care.

"Assistive technology" or "AT" means specialized medical equipment and supplies, including those devices, controls, or appliances specified in the plan of care but not available under the State Plan for Medical Assistance, that (i) enable individuals to increase their abilities to perform ADLs and to perceive, control, or communicate with the environment in which they live or (ii) are necessary for the proper functioning of the specialized equipment; cost effective; and appropriate for the individual's assessed medical needs and physical deficits.

"Backup caregiver" means the secondary person who will assume the role of providing direct care to and support of the waiver individual in instances of emergencies and in the absence of the primary caregiver who is unable to care for the individual. Such secondary persons shall perform the duties needed by the waiver individual without compensation and shall be trained in the skilled needs and technologies required by the waiver individual. Such secondary persons must be identified in the waiver individual's records.

"Barrier crime" means those crimes as defined in § 32.1-162.9:1 of the Code of Virginia that would prohibit the continuation of employment if a person is found, through a Virginia State Police criminal history record check, to have been convicted of such a crime.

"CMS-485 Home Health Certification form" means the federal Home Health Service Plan form.

"Center for Medicare and Medicaid Services" or "CMS" means the unit of the U.S. Department of Health and Human Services that administers the Medicare and Medicaid programs.

"Child Protective Services" or "CPS" means a program overseen by the Department of Social Services which investigates reports of abuse, neglect, and exploitation of children under 18 years of age and provides services when persons are found to be in need of protective services.

"Code of Federal Regulations" or "CFR" contains the regulations that have been officially adopted by federal agencies and have the force and effect of federal law.

"Congregate living arrangement" means a living arrangement in which three or fewer waiver individuals live in the same household and share receipt of health care services from the same provider or providers.

"Congregate skilled private duty nursing" means skilled in-home nursing provided to three or fewer waiver individuals in the individuals' primary residence or a group setting.

"Congregate private duty respite" means skilled respite care provided to three or fewer waiver individuals. This service shall be limited to 240 hours per calendar year per household.

"Cost-effective" means the anticipated annual cost to Medicaid for technology assisted waiver services shall be less than or equal to the anticipated annual institutional costs to Medicaid for individuals receiving care in hospitals or specialized care nursing facilities.

"Day" means, for the purpose of reimbursement under this waiver, a 24-hour period beginning at 12 a.m. and ending at 11:59 p.m.

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

"DMAS" means the Department of Medical Assistance Services.

"Direct marketing" means one of the following: (i) conducting directly or indirectly door-to-door, telephonic or other "cold call" marketing of services at residences and provider sites; (ii) mailing directly; (iii) paying "finders' fees"; (iv) offering financial incentives, rewards, gifts, or special opportunities to eligible individuals and the individual's family/caregiver, as appropriate, as inducements to use the providers' services; (v) continuous, periodic marketing activities to the same prospective individual and the individual's family/caregiver, as appropriate, for example, monthly, quarterly, or annual giveaways as inducements to use the providers' services; or (vi) engaging in marketing activities that offer potential customers rebates or discounts in conjunction with the use of the providers' services or other benefits as a means of influencing the individual and the individual's family/caregiver, as appropriate, use of the providers' services.

"Direct medical benefit" means services or supplies that are proper and needed for the diagnosis or treatment of a medical condition; are provided for the diagnosis, direct care, and treatment of the condition; and meet the standards of good professional medical practice.

"Direct supervision" means that the supervising registered nurse (RN) is immediately accessible by phone to the RN, licensed practical nurse or personal care aide who is delivering waiver covered services to individuals.

"Durable medical equipment (DME) and supplies" means those items prescribed by the attending physician, generally recognized by the medical community as serving a diagnostic or therapeutic purpose to assist the waiver individual in the home environment, and as being a medically necessary element of the service plan without regard to whether those items are covered by the State Plan for Medical Assistance.

"Eligibility determination" is the process to determine whether an individual meets the eligibility requirements specified by DMAS to receive Medicaid benefits and continues to be eligible as determined annually.

"Enrolled provider" means those professional entities or facilities who are registered, certified, or licensed, as appropriate, and who are also enrolled by DMAS to render services to eligible waiver individuals and receive reimbursement for such services.

"Enrollment" means the process where an individual has been determined to meet the eligibility requirements for a

Medicaid program or service and the approving entity has verified the availability of services for the individual requesting waiver enrollment and services.

"Environmental modifications" or "EM" means physical adaptations to an individual's primary residence or primary vehicle that are necessary to ensure the individual's health, safety, or welfare or that enable the individual to function with greater independence and without which the individual would require institutionalization.

"EPSDT" means the Early Periodic Screening, Diagnosis and Treatment program administered by DMAS for children under 21 years of age according to federal guidelines that prescribe preventive and treatment services for Medicaid-eligible children as set out in 12VAC30-50-130.

"Evaluation tool" means the tool that is used to determine the medical appropriateness for technology assisted waiver enrollment or services. Individuals younger than 21 years of age shall be assessed using the Technology Assisted Waiver Pediatric Referral Form (DMAS-109) and individuals 21 years of age or older shall be assessed using the Technology Assisted Waiver Adult Referral form (DMAS-108).

"Freedom of choice" means the right afforded an individual who is determined to require a level of care specified in a waiver to choose (i) either institutional or home and community-based services provided there are available funded slots, (ii) providers of services, and (iii) waiver services as may be limited by medical necessity.

"Functional status" means an individual's degree of dependence in performing ADLs.

"Health, safety, and welfare standard" means that an individual's right to receive a waiver service is dependent on a DMAS determination that the waiver individual needs the medically necessary service based on appropriate assessment criteria and an approved written plan of care and that medically necessary services can be safely provided in the community.

"Home and community-based waiver services" or "waiver services" means the range of home and community services approved by the CMS pursuant to § 1915(c) of the Social Security Act to be offered to individuals as an alternative to institutionalization.

"Individual" means the person who has applied for and been approved to receive technology assisted waiver services.

"Individual's representative" means a spouse, guardian, adult child, parent (natural, adoptive, step, or foster) of a minor child, or other person chosen by the member to represent him in matters relating to his care or to function as the member's primary caregiver as defined herein.

"Instrumental activities of daily living" or "IADLs" means tasks such as meal preparation, shopping, housekeeping, and laundry. An individual's degree of independence in performing these activities is a part of determining the appropriate level of care and service needs.

"Legally responsible person" means one who has a legal obligation under the provisions of state law to care for and make decisions for an individual. Legally responsible persons shall include the parents (natural, adoptive, or legal guardian) of minor children, and legally assigned caregiver relatives of minor children.

"Level of care" or "LOC" means the specification of the minimum amount of assistance an individual must require in order to receive services in an institutional setting under the State Plan for Medical Assistance Services or to receive waiver services.

"License" means proof of official or legal permission issued by the government for an entity or person to perform an activity or service. In the absence of a license that may be required by either statute or regulation, the entity or person shall be prohibited from performing the activity or service for reimbursement by DMAS.

"Licensed practical nurse" or "LPN" means a person who is licensed or holds a multi-state licensure privilege, pursuant to Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia, to practice practical nursing as defined.

"Long-term care" or "LTC" means a variety of services that help individuals with health or personal care needs and ADLs over a period of time. Long-term care can be provided in the home, in the community, or in various types of facilities, including nursing facilities, long-stay hospitals, and ICFs/MR.

"Medicaid" means the joint federal and state program to assist the states in furnishing medical assistance to eligible needy persons pursuant to Title XIX of the Social Security Act (42 USC § 1396 et seq.).

"Medicaid Long Term Care Communication Form" or "DMAS-225" means the form used to exchange eligibility information of a Medicaid-eligible individual or other information that may affect the individual's eligibility status.

"Medically necessary" means those services or specialized medical equipment or supplies that are covered for reimbursement under either the State Plan for Medical Assistance or in a waiver program that are reasonable, proper, and necessary for the treatment of an illness, injury, or deficit; are provided for direct care of the condition or to maintain or improve the functioning of a malformed body part; and that meet the standards of good professional medical practice as determined by DMAS.

"Minor child" means an individual who is younger than 21 years of age.

"Money Follows the Person" or "MFP" means the program of transition services and coordination as set out in 12VAC30-120-2000 and 12VAC30-120-2010.

"Monitoring" means the ongoing oversight of the provision of waiver and other services to determine that they are furnished according to the waiver individual's plan of care and effectively meet his needs, thereby assuring his health,

safety, and welfare. Monitoring activities may include, but shall not be limited to, telephone contact; observation; interviewing the individual or the trained individual representative, as appropriate, in person or by telephone; or interviewing service providers.

"Participating provider" or "provider" means an entity that meets the standards and requirements set forth by the appropriate licensing or certification agencies and who has a current, signed provider participation agreement with DMAS.

"Payor of last resort" means all other payment sources must be exhausted before enrollment in the technology assisted waiver and Medicaid reimbursement may occur.

"Personal care aide" or "PCA" means an appropriately licensed or certified person who provides personal care services.

"Personal care provider" means an enrolled provider that renders services that prevent or reduce institutional care by providing eligible waiver individuals with PCAs who provide personal care services.

"Personal care (PC) services" means a range of support services that includes assistance with ADLs, access to the community, and self-administration of medication or other medical needs, and the monitoring of health status and physical condition provided through the agency-directed model. Personal care services shall be provided by PCAs within the scope of their licenses or certifications, as appropriate.

"Person-centered planning" means a process, directed by the individual or his representative, as appropriate, that is intended to identify the strengths, capacities, preferences, needs, and desired outcomes for the individual.

"Plan of care" or "POC" means the written plan of waiver services and supplies ordered and certified by the attending physician as being medically needed by the individual to ensure optimal health and safety for an extended period of time while the individual is living in the community. This POC shall be developed collaboratively by the individual or individual representative, as appropriate.

"Preadmission screening" or "PAS" means the process to (i) evaluate the functional, nursing, and social support needs of applicants referred for preadmission screening; (ii) assist applicants in determining what specific services the applicants need; (iii) evaluate whether a service or a combination of existing community services are available to meet the applicants' needs; and (iv) refer applicants to the appropriate provider for Medicaid-funded facility or home and community-based care for those who meet specialized care nursing facility level of care.

"Preadmission screening team" or "PAS team" means the entity contracted with DMAS that is responsible for performing preadmission screening pursuant to § 32.1-330 of the Code of Virginia.

"Primary caregiver" means the primary person who consistently assumes the role of providing direct care and support of the individual to live successfully in the community without compensation for providing such care.

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

"Prior authorization contractor" means DMAS or the entity that has been contracted by DMAS to perform prior authorization for medically necessary Medicaid reimbursed home and community-based services.

"Provider agreement" means the contract between DMAS and a participating provider under which the provider agrees to furnish services to Medicaid-eligible individuals in compliance with state and federal statutes and regulations and Medicaid contract requirements.

"Reevaluation" means the periodic but at least annual review of an individual's condition and service needs to determine whether the individual continues to meet the LOC specified for persons approved for waiver participation.

"Registered nurse" or "RN" means a person who is licensed or holds a multi-state licensure privilege pursuant to Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia to practice professional nursing as defined.

"Single state agency" means the agency within state government that has been designated pursuant to § 1902(a)(5) of the Act as responsible for the administration of the State Plan for Medical Assistance. In Virginia, the single state agency is DMAS.

"Skilled private duty nursing respite care provider" means a DMAS participating provider that renders services in the individual's designated primary care residence to offer periodic or routine relief for unpaid primary caregivers.

"Skilled private duty nursing respite care services" means temporary skilled nursing services provided in the waiver individual's primary residence that are designed to relieve the unpaid primary caregiver on an episodic or routine basis for short periods or for specified longer periods of time.

"Skilled private duty nursing services" or "skilled PDN" means skilled in-home nursing services listed in the POC that are (i) not otherwise covered under the State Plan for Medical Assistance Services home health benefit; (ii) required to prevent institutionalization; (iii) provided within the scope of the Commonwealth's Nurse Practice Act and Drug Control Act (Chapters 30 (§ 54.1-3000 et seq.) and 34 (§ 54.1-3400 et seq.) of Title 54.1 of the Code of Virginia, respectively); and (iv) provided by a licensed RN, or by an LPN under the supervision of an RN, to waiver members who have serious medical conditions or complex health care needs. Skilled nursing services are to be used as hands-on member care,

training, consultation, as appropriate, and oversight of direct care staff, as appropriate.

"State Plan for Medical Assistance" or "State Plan" means the Commonwealth's legal document approved by CMS identifying the covered groups, covered services and their limitations, and provider reimbursement methodologies as provided for under Title XIX of the Social Security Act.

"Technology assisted waiver" or "tech waiver" means the CMS-approved waiver that provides medically necessary covered services to individuals who are chronically ill or severely impaired, having experienced loss of a vital body function, and who require substantial and ongoing skilled nursing care to avert death or further disability and whose illness or disability would, in the absence of services approved under this waiver, require their admission for a prolonged stay in a hospital or specialized care nursing facility.

"Termination" means disenrollment from a waiver by DMAS or a DMAS-designated agent.

"Transition services" means set-up expenses for individuals as defined at 12VAC30-120-2010.

"Virginia Department of Health" or "VDH" means the state Health Department.

"VDSS" means the Virginia Department of Social Services.

"Ventilator dependence" means that the waiver individual is dependent on such machines in order to sustain life or compensate for the loss of body function.

"Virginia Uniform Assessment Instrument" or "UAI" means the standardized multidimensional questionnaire that assesses an individual's physical health, mental health, psychosocial, and functional abilities to determine if the individual meets the nursing facility LOC.

12VAC30-120-1705. Waiver description and legal authority.

A. Home and community-based waiver services shall be available through a § 1915(c) waiver of the Social Security Act. Under this waiver, DMAS has waived § 1902(a) (10) (B) and (C) of the Social Security Act related to comparability of services.

B. Technology assisted waiver services shall be covered only for Medicaid-eligible individuals who have been determined eligible for waiver services and who also require the level of care provided in either long-stay hospitals or specialized care nursing facilities as long as age appropriate criteria are met. These services shall be the critical service necessary to delay or avoid the individual's placement in an appropriate facility. These waiver services shall not be covered for Medicaid-eligible individuals who reside in, but not necessarily limited to, the following types of facilities: assisted living facilities, nursing facilities, rehabilitation hospitals, long-stay hospitals, skilled or intermediate care nursing facilities, Intermediate Care Facilities for the Mentally Retarded, group homes licensed by DBHDS, general acute care hospitals or adult foster care homes.

C. An individual must demonstrate the medical necessity for skilled private duty nursing services in order to be approved for this waiver.

D. The cost effectiveness standard that shall be applied for individuals in this waiver shall be in the aggregate.

E. Tech waiver services shall not be offered or provided to an individual who resides outside of the continental United States or travels out of the Commonwealth. However, brief absences from the Commonwealth for up to 14 days per calendar year may be made for vacations but such absences shall be authorized by DMAS and limited to the same number of skilled PDN hours approved for the individual's home-based skilled PDN.

F. An individual shall not simultaneously be in a managed care program and enrolled in this waiver. An individual shall not be simultaneously enrolled in more than one waiver program.

G. For individuals admitted to this waiver, when their waiver services must be interrupted due to their primary caregiver's emergency unavailability, then hospitalization or placement in a specialized nursing facility, should a specialized care nursing facility bed be available, shall occur.

H. DMAS shall be responsible for assuring appropriate placement of the individual in home and community based waiver services and shall have the authority to terminate such services.

I. No waiver services shall be reimbursed until after both the provider enrollment process and individual eligibility process have been completed.

12VAC30-120-1710. Individual eligibility requirements; preadmission screening.

A. Individual eligibility requirements.

1. The Commonwealth covers these optional categorically needy groups: ADC and AFDC-related individuals, SSI and SSA-related individual, aged, blind, or disabled Medicaid-eligible individuals under 42 CFR 435.121, and the home and community-based waiver group at 42 CFR 435.217 that includes individuals who are eligible under the State Plan if they were institutionalized.

a. The income level used for the home and community-based waiver group at 42 CFR 435.217 shall be 300% of the current Supplemental Security Income payment standard for one person.

b. Medically needy Medicaid-eligible individuals shall be eligible if they meet the medically needy financial requirements for income and resources.

2. Under this waiver, the coverage groups authorized under § 1902(a)(10)(A)(ii)(VI) of the Social Security Act shall be considered as if they were institutionalized for the purpose of applying institutional deeming rules. All individuals in

the waiver must meet the financial and non-financial Medicaid eligibility criteria and meet the institutional LOC criteria. The deeming rules shall be applied to waiver eligible individuals as if they were residing in an institution or would require that level of care.

3. An applicant for technology assisted waiver shall meet specialized care nursing facility criteria, including both medical and functional needs, and also be dependent on waiver services to avoid or delay facility placement and meet all criteria for the age appropriate assessments in order to be eligible for the tech waiver. Applicants shall not be enrolled in the tech waiver unless skilled PDN hours are ordered by the physician. The number of skilled PDN hours shall be based on the total technology and nursing score on the Technology Assisted Waiver Pediatric Referral (when individuals are less than 21 years of age). The number of skilled PDN hours for adults shall be based on the Technology Assisted Waiver Adult Referral (DMAS-108).

4. Applicants who are eligible for third-party payment for skilled private duty nursing services shall not be eligible for these waiver services. If an individual or an individual's legally responsible party voluntarily drops any insurance plan that would have provided coverage of skilled private duty nursing services in order to become eligible for these waiver services within one year prior to the date waiver services are requested, eligibility for the waiver shall be denied. From the date that such insurance plan is discontinued, such applicants shall be barred for one year from reapplying for waiver services. After the passage of the one-year time period, the applicant may reapply to DMAS for admission to the tech waiver.

5. In addition to the medical needs identified in this section, the Medicaid-eligible individual shall be determined to need substantial and ongoing skilled nursing care. The Medicaid-eligible individual shall be required to meet a minimum standard on the age appropriate referral forms to be eligible for enrollment in the tech waiver.

6. Medicaid-eligible individuals who entered the waiver prior to their 21st birthday shall, on the date of their 21st birthday, conform to the adult medical criteria and cost-effectiveness standards.

7. Every individual who applies for Medicaid-funded waiver services must have his Medicaid eligibility evaluated or re-evaluated, if already Medicaid eligible, by the local DSS in the city or county in which he resides. This determination shall be completed at the same time the Pre-admission Screening (PAS) team completes its evaluation (via the use of the Uniform Assessment Instrument (UAI)) of whether the applicant meets waiver criteria. DMAS payment of waiver services shall be contingent upon the DSS' determination that the individual is eligible for Medicaid services for the dates that waiver services are to be provided and that DMAS or the designated prior authorization contractor has authorized waiver enrollment and has prior authorized the services that will be required by the individual.

8. In order for an enrolled waiver individual to retain his enrolled status, tech waiver services must be used by the individual at least once every 30 days. Individuals who do not utilize tech waiver services at least every 30 days shall be terminated from the waiver.

9. The waiver individual shall have a trained primary caregiver, as defined in 12VAC30-120-1700, who accepts responsibility for the individual's health, safety, and welfare. This primary caregiver shall be responsible for a minimum of eight hours of the individual's care in a 24-hour period as well as any hours not provided by an RN or an LPN. The name of the trained primary caregiver shall be documented in the provider agency records. This trained primary caregiver shall also have a back up system available in emergency situations.

B. Screening and community referral for authorization for tech waiver. Tech waiver services shall be considered only for individuals who are eligible for Medicaid and for admission to a specialized care nursing facility, ICF/MR, long-stay hospital, or acute care hospital when those individuals meet all the criteria for tech waiver admission. Such individuals, with the exception of those who are transferring into this tech waiver from a long-stay hospital, shall have been screened using the Uniform Assessment Instrument (UAI).

1. The screening team shall provide the individual and family or caregiver with the choice of tech waiver services or specialized care nursing facility or long-stay hospital placement, as appropriate, as well as the provider of those services from the time an individual seeks waiver information or application and referral. Such provision of choice includes the right to appeal pursuant to 12VAC30-110 when applicable.

2. The screening team shall explore alternative care settings and services to provide the care needed by the applicant being screened when Medicaid-funded home and community based care services are determined to be the critical service necessary to delay or avoid facility placement.

3. Individuals must be screened to determine necessity for nursing facility placement if the individual is currently financially Medicaid eligible or anticipates that he will be financially eligible within 180 days of the receipt of nursing facility care or if the individual is at risk of nursing facility placement.

a. Such covered waiver services shall be critical, as certified by the participant's physician at the time of assessment, to enable the individual to remain at home and in the community rather than being placed in an institution. In order to meet criteria for tech waiver

enrollment, the applicant requesting consideration for waiver enrollment must meet the level of care criteria.

b. Individuals who are younger than 21 years of age shall have the Technology Assisted Waiver Pediatric Referral Form (DMAS-109) completed and must need substantial and ongoing nursing care as indicated by a minimum score of at least 50 points to qualify for waiver enrollment. This individual shall need a medical device and ongoing skilled PDN care by meeting the categories described in subdivision (1), (2), or (3) below:

(1) Applicants depending on mechanical ventilators;

(2) Applicants requiring prolonged intravenous administration of nutritional substances or drugs or requiring ongoing peritoneal dialysis; or

(3) Applicants having daily dependence on other device-based respiratory or nutritional support, including tracheostomy tube care, oxygen support, or tube feeding.

c. Individuals who are 21 years of age or older shall have the Technology Assisted Waiver Adult Referral Form (DMAS-108) completed and must be found to be dependent on a ventilator or must meet all eight specialized care criteria (12VAC30-60-320) for complex tracheostomy care in order to qualify for waiver enrollment.

4. When an applicant has been determined by DSS to meet the financial and waiver eligibility requirements and DMAS has verified the availability of the services for that individual and that the individual has no other payment sources for skilled PDN, tech waiver enrollment and entry into home and community-based care may occur.

5. Preadmission screenings are considered valid for the following time frames for all LTC services. The following time frames apply to individuals who have been screened but have not received either institutional or community based services during the periods shown below:

a. Zero to six months: screenings are valid and do not require updates;

b. Six months to 12 months: screening updates are required; however, no additional reimbursement is made by DMAS; and

c. Over 12 months: a new screening is required. Additional reimbursement shall be made by DMAS for the repeated screening.

6. When an individual was not screened prior to admission to a specialized care nursing facility, or the individual resides in the community at the time of referral initiation to DMAS, the locality in which the individual resides at the time of discharge must complete the preadmission screening prior to enrollment into the tech waiver.

7. The individual's attending physician and DMAS shall be the final determining bodies for enrollment in the tech waiver and the determination of the number of approved skilled PDN hours for which DMAS will pay. DMAS has the ultimate responsibility for authorization of Medicaid skilled PDN reimbursement for tech waiver services.

C. Waiver individuals' rights and responsibilities. DMAS shall ensure that:

1. Each waiver individual shall receive and the provider and provider staff shall provide the necessary care and services, to the extent of provider availability, to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the individual's comprehensive assessment and POC.

2. Waiver individuals shall have the right to receive services from the provider with reasonable accommodation of the individuals' needs and preferences except when DMAS makes a determination that the health, safety, or welfare of the individuals or other waiver individuals would be endangered.

3. Waiver individuals formulate their own advance directives based on information that providers must give to adult waiver individuals at the time of their admissions to services.

4. All waiver individuals shall have the right to:

a. Voice grievances to the provider or provider staff without discrimination or reprisal. Such grievances include those with respect to treatment that has been furnished or has not been furnished;

b. Prompt efforts by the provider or staff, as appropriate, to resolve any grievances the waiver individual may have;

c. Be free from verbal, sexual, physical, and mental abuse, neglect, exploitation, and misappropriation of property;

d. Be free from any physical or chemical restraints of any form that may be used as a means of coercion, discipline, convenience, or retaliation and that are not required to treat the individual's medical symptoms; and

e. Their personal privacy and confidentiality of their personal and clinical records.

5. Waiver individuals shall be provided by their healthcare providers, at the time of their admission to this waiver, with written information regarding their rights to participate in medical care decisions, including the right to accept or refuse medical treatment and the right to formulate advance directives.

6. The legally competent waiver individual, the waiver individual's legal guardian, or the parent (natural, adoptive or foster) of the minor child shall have the right to:

a. Choose whether the individual wishes to receive home and community-based care waiver services instead of institutionalization in accordance with the assessed needs of the individual. The PAS team shall inform the individual of all available waiver service providers in the

community in which the waiver individual resides. The tech waiver individual shall have the option of selecting the provider and services of his choice. This choice must be documented in the individual's medical record;

b. Choose his own primary care physician in the community in which he lives;

c. Be fully informed in advance about the waiver POC and treatment needs as well as any changes in that care or treatment that may affect the individual's well-being; and

d. Participate in the care planning process and choice of providers and services.

12VAC30-120-1720. Covered services; limits; changes to or termination of services.

A. Coverage statement.

1. These waiver services shall be medically necessary, cost-effective as compared to the costs of institutionalization, and necessary to maintain the individual safely in the community and prevent institutionalization.

2. Services shall be provided only to those individuals whose service needs are consistent with the service description and for which providers are available who have adequate and appropriate staffing to meet the needs of the individuals to be served.

3. All services covered through this waiver shall be rendered according to the individuals' POCs that have been certified by physicians as medically necessary and also reviewed by DMAS to enable the waiver enrolled individuals to remain at home or in the community.

4. Providers shall be required to refund payments received to DMAS if they (i) are found during any review to have billed Medicaid contrary to policy, (ii) have failed to maintain records to support their claims for services, or (iii) have billed for medically unnecessary services.

5. DMAS shall perform prior authorization for skilled PDN services, skilled private duty respite services, PC for adults, and transition services. DMAS or the prior authorization contractor shall perform prior authorization for AT services and EM services.

6. When a particular service requires prior authorization, reimbursement shall not be made until the prior authorization is secured from either DMAS or the DMAS-designated prior authorization contractor.

B. Covered services. Covered services shall include: skilled PDN; skilled private duty respite care; assistive technology; environmental modifications; and transition services only for individuals needing to move from a designated institution into the community or for waiver individuals who have already moved from an institution within 30 days of their transition. Coverage shall not be provided for these services for individuals who reside in any facilities enumerated in 12VAC30-120-1705. Skilled PDN shall be a required service. If an individual has no medical necessity for skilled PDN, he shall not be admitted to this waiver. All other services provided in this waiver shall be provided in conjunction with the provision of skilled PDN.

1. Skilled PDN, for a single individual and congregate group settings, as defined in 12VAC30-120-1700, shall be provided for waiver enrolled individuals who have serious medical conditions or complex health care needs. To receive this service, the individuals must require specific skilled and continuous nursing care on a regularly scheduled or intermittent basis performed by an RN or an LPN. Upon completion of the required screening and required assessments and a determination that the individual needs substantial and ongoing skilled nursing care and waiver enrollment then the PDN hours shall be authorized by the DMAS staff.

a. PDN services shall be rendered according to a POC authorized by DMAS and shall have been certified by a physician as medically necessary to enable the individual to remain at home.

b. No reimbursement shall be provided by DMAS for either RN or LPN services without signed physician orders that specifically identify skilled nursing tasks to be performed for the individual.

c. Limits placed on the amount of PDN that will be approved for reimbursement shall be consistent with the individual's total points on the age-appropriate Tech Waiver Referral Form (DMAS-108) and medical necessity. In no instances shall the individual's POC or ongoing multiple POCs result in coverage of more than 16 hours of PDN in a 24-hour period per household or congregate group setting except for minor individuals during the first 15 calendar days after initial waiver admission.

(1) The number of skilled PDN hours for minor individuals shall be based on the total technology and nursing score on the DMAS Tech Waiver Staff Assessment and updated by the DMAS staff when changes occur and with annual waiver eligibility redetermination by DMAS.

(2) Once the minor individual's composite score (total score) is derived, a LOC is designated for the individual as a Level A, B, or C. This LOC designation determines the maximum number of hours per day of skilled PDN a pediatric individual may have allocated on the DMAS skilled PDN authorization form (Department of Medical Assistance Internal Document). Any hours beyond the maximum for such individual's LOC must be medically necessary and prior authorized by DMAS. Any POC submitted without approval for hours beyond the maximum for any particular LOC will only be entered for the maximum for that LOC. The results of the scoring assessment determine the maximum amount of hours available and authorization shall occur as follows:

(a) 50 – 56 points = 10 hours per day

(b) 57 – 79 points = 12 hours per day

(c) 80 points or greater = 16 hours per day

(3) For minor individuals, whether living separately or in a congregate setting, during the first 15 calendar days after such individuals' initial admission to the waiver, skilled PDN may be covered for up to 24-hours per day, if needed and appropriate to assist the family in adjustment to the care associated with technology assistance. After these first 15 calendar days, skilled PDN shall be reimbursed up to a maximum of 16 hours per 24-hour day period per household.

(4) When reimbursement is to be made for skilled PDN services to be provided in schools, the nurse shall be in the same room as the waiver individual for the hours of skilled PDN care billed. When an individual receives skilled PDN while attending school, the total skilled PDN hours shall not exceed the authorized number of hours under his nursing score category on the Technology Assisted Waiver Pediatric Referral Form (DMAS-109).

(5) The making up or trading of any missed scheduled shifts, days or hours of care may be done within 72 hours of the missed scheduled shift but the total hours made up, including for any day, shall not exceed 16 hours per day for any reason.

(6) For adult individuals, whether living separately or in a congregate group, skilled PDN shall be reimbursed up to a maximum of 16 hours within a 24-hour period per household provided that the cost-effectiveness standard is not exceeded for the individual's care.

(7) The adult individual shall be determined to need a medical device and ongoing skilled nursing care when such individual meets Category A or all eight criteria in Category B:

(a) Category A. Individuals who depend on mechanical ventilators; or

(b) Category B. Individuals who have a complex tracheostomy as defined by:

(i) Tracheostomy with the potential for weaning off of it, or documentation of attempts to wean, with subsequent inability to wean;

(ii) Nebulizer treatments ordered at least four times a day or nebulizer treatments followed by chest physiotherapy provided by a nurse or respiratory therapist at least four times a day;

(iii) Pulse oximetry monitoring at least every shift due to unstable oxygen saturation levels;

(iv) Respiratory assessment and documentation every shift by a licensed respiratory therapist or nurse;

(v) Have a physician's order for oxygen therapy with documented usage;

(vi) Receives tracheostomy care at least daily;

(vii) Has a physician's order for tracheostomy suctioning; and

(viii) Deemed at risk to require subsequent mechanical ventilation.

(8) Skilled PDN services shall be available to individuals in their primary residence with some community integration (i.e., medical appointments and school) permitted.

(9) Skilled PDN services may include consultation and training for the primary caregiver.

d. The provider shall be responsible for notifying DMAS should the primary residence of the individual be changed or should the individual be hospitalized or should the individual die.

e. Exclusions from DMAS' coverage of skilled PDN:

(1) This service shall not be authorized when intermittent skilled nursing visits could be satisfactorily utilized while protecting the health, safety, and welfare of the individual.

(2) Skilled PDN hours shall not be reimbursed while the individual is receiving emergency care or during emergency transport of the individual to such facilities. The RN or LPN shall not transport the waiver individual to such facilities.

(3) Skilled PDN services may be ordered but shall not be provided simultaneously with PDN respite care or personal care services as described in 12VAC30-120-1720.

(4) Parents (natural, adoptive, legal guardians), spouses, siblings, grandparents, grandchildren, adult children, other legal guardians, or any person living under the same roof with the individual shall not provide skilled PDN services for the purpose of Medicaid reimbursement for the waiver individual.

(5) Providers shall not bill prior to receiving the physician's dated signature on the individual's POC for services provided and the DMAS staff's authorization/determination of skilled PDN hours.

(6) Time spent driving the waiver individual shall not be reimbursed by DMAS.

f. Congregate skilled PDN.

(1) If more than one waiver individual will reside in the home, the same waiver provider or providers shall be chosen to provide all skilled PDN services for all waiver individuals in the home.

(2) Only one nurse shall be authorized to care for each two waiver individuals in such arrangements. In instances when three waiver individuals share a home, nursing ratios shall be determined by DMAS or its designated agent based on the needs of all the individuals

who are living together. These congregate skilled PDN hours shall be at the same scheduled shifts.

(3) The primary caregiver shall be shared and shall be responsible for providing at least eight hours of skilled PDN care per 24 hours as well as all skilled PDN care needs in the absence of the provider agency.

(4) DMAS shall not reimburse for skilled PDN services through the tech waiver and skilled PDN services through the EPSDT benefit for the same individual at the same time.

2. Skilled private duty respite care services. Skilled private duty respite care services may be covered for a maximum of 240 hours per calendar year regardless of waiver for individuals who are qualified for tech waiver services and regardless of whether the waiver individual changes waivers and who have an primary caregiver who requires temporary or intermittent relief from the burden of care giving.

a. This service shall be provided by skilled nursing staff licensed to practice in the Commonwealth under the direct supervision of a home health agency licensed certified or accredited and with which DMAS has a provider agreement to provide skilled PDN.

b. Skilled private duty respite care services shall be comprised of both skilled and hands-on care of either a supportive or health-related nature and may include, but shall not be limited to, all skilled nursing care as ordered on the physician-certified POC, assistance with ADLs, administration of medications or other medical needs, and monitoring of the health status and physical condition of the individual or individuals.

c. When skilled private duty respite services are offered in conjunction with skilled PDN, the same individual record may be used with a separate section for skilled private duty respite services documentation.

d. Individuals who are living in congregate arrangements shall be permitted to share skilled private duty respite care service providers. The same limits on this service in the congregate setting (240 hours per calendar year per household) shall apply regardless of the waiver.

e. Skilled private duty respite care services shall be provided in the individual's primary residence as is designated upon admission to the waiver.

3. Assistive technology services. Assistive technology, as defined in 12VAC30-120-1700, devices must be portable and shall be authorized per calendar year.

a. AT services shall be available for enrolled waiver individuals who are receiving skilled PDN and are the specialized medical equipment and supplies, including those devices, controls, or appliances, specified in the individual's plan of care, but that are not available under the State Plan for Medical Assistance, that enable waiver individuals to increase their abilities to perform ADLs, or to perceive, control, or communicate with the environment in which they live. This service includes ancillary supplies, and equipment necessary to the proper functioning of such items.

b. An independent, professional consultation must be obtained from qualified professionals who are knowledgeable of that item for each AT request prior to approval by DMAS or the designated prior authorization contractor. Individual professional consultants include speech/language therapists, physical therapists, occupational therapists, physicians, certified rehabilitation engineers or rehabilitation specialists. A prescription shall not meet the standard of an assessment.

c. In order to qualify for these services, the individual must have a demonstrated need for equipment for remedial or direct medical benefit primarily in the individual's primary residence or primary vehicle to specifically serve to improve the individual's personal functioning.

d. AT shall be covered in the least expensive, most cost-effective manner. The cost of AT services shall be included in the total cost of waiver services.

e. Service units and service limitations. AT equipment and supplies shall not be rented but shall be purchased through a Medicaid-enrolled durable medical equipment provider.

(1) The service unit is always one, for the total cost of all AT being requested for a specific timeframe. The maximum Medicaid-funded expenditure per individual for all AT covered procedure codes combined shall be pursuant to 12VAC30-120-762.

(2) The cost for AT shall not be carried over from one calendar year to the next. Each item must be prior authorized by either DMAS or the DMAS designated contractor for each calendar year.

(3) Unexpended portions of the maximum amount shall not be accumulated across one or more calendar years to be expended in a later year.

(4) Shipping/freight/delivery charges are not billable to DMAS or the waiver individual, as such charges are considered noncovered items.

(5) All products must be delivered, demonstrated, installed and in working order prior to submitting any claim for them to Medicaid.

(6) The date of service on the claim must be within the prior authorization approval dates, which may be prior to the delivery date as long as the initiation of services commenced during the approved dates.

(7) The prior authorization shall not be modified to accommodate delays in product deliveries. In such situations, new prior authorizations must be sought by the provider.

(8) When two or more waiver individuals live in the same home or congregate living arrangement, the AT shall be shared to the extent practicable consistent with the type of AT.

f. AT exclusions.

(1) Medicaid shall not reimburse for any AT devices or services that may have been rendered prior to authorization from DMAS or the designated prior authorization contractor.

(2) Providers of AT shall not be spouses, parents (natural, adoptive, or foster), or stepparents of the individual who is receiving waiver services. Providers that supply AT for the waiver individual may not perform assessments/consultation or write specifications for that individual. Any request for a change in cost (either an increase or a decrease) requires justification and supporting documentation of medical need and prior authorization by DMAS or the designated prior authorization contractor. The vendor must receive a copy of the professional evaluation in order to purchase the items recommended by the professional. If a change is necessary then the vendor must notify the assessor to ensure the changed items meet the individual's needs.

(3) All equipment or supplies already covered by a service provided for in the State Plan shall not be purchased under the waiver as AT. Such examples are, but shall not necessarily be limited to:

(a) Specialized medical equipment, durable or nondurable medical equipment (DME), ancillary equipment, and supplies necessary for life support;

(b) Adaptive devices, appliances, and controls that enable an individual to be more independent in areas of personal care and ADLs, and;

(c) Equipment and devices that enable an individual to communicate more effectively.

(4) AT services shall not be approved for purposes of the convenience of the caregiver, restraint of the individual, recreation or leisure, educational purposes, or diversion activities. Examples of these types of items shall be listed in DMAS guidance documents.

4. Environmental modifications services shall be covered as defined in 12VAC30-120-1700. Medicaid reimbursement shall not occur before prior authorization of EM services is completed by DMAS or the DMAS-designated prior authorization contractor. EM services shall entail limited physical adaptations to preexisting structures and shall not include new additions to an existing structure that simply increase the structure's square footage.

a. In order to qualify for EM services, the individual must have a demonstrated need for modifications of a remedial nature or medical benefit to the primary residence to specifically improve the individual's personal functioning. Such modifications may include, but shall not necessarily be limited to, the installation of ramps and grab-bars, widening of doorways and other adaptations to accommodate wheelchairs, modification of bathroom facilities to accommodate wheelchairs (but not strictly for cosmetic purposes), or installation of specialized electrical and plumbing systems required to accommodate the medical equipment and supplies that are necessary for the individual's welfare. Modifications may include a generator for waiver individuals who are dependent on mechanical ventilation for 24-hours a day and when the generator is used to support the medical equipment and supplies necessary for the individual's welfare.

b. EM shall be available costing up to a maximum amount of $5,000 per calendar year regardless of waiver for individuals who are receiving skilled PDN services. Effective January 1, 2011, the maximum Medicaid-funded expenditure per individual for all EM-covered procedure codes combined shall be pursuant to 12VAC30-120-758.

c. Costs for EM shall not be carried over from one calendar year to the next year. Each item shall be prior authorized by DMAS or the DMAS-designated agent for each calendar year. Unexpended portions of this maximum amount shall not be accumulated across one or more years to be expended in a later year.

d. When two or more waiver individuals live in the same home or congregate living arrangement, the EM shall be shared to the extent practicable consistent with the type of requested modification.

e. Only the actual cost of material and labor is reimbursed. There shall be no additional markup.

f. EM shall be carried out in the most cost-effective manner possible to achieve the goal required for the individual's health, safety, and welfare. The cost of EM waiver services shall be included in the individual's costs of all other waiver services, which shall not exceed the total annual cost for placement in an institution.

g. All services shall be provided in the individual's primary residence in accordance with applicable state or local building codes and appropriate permits or building inspections which shall be provided to DMAS or the DMAS contractor.

h. Proposed modifications that are to be made to rental properties must have prior written approval of the property's owner. Modifications to rental properties shall only be valid if it is an independently operated rental facility with no direct or indirect ties to any other Medicaid service provider.

i. Modifications may be made to a vehicle if it is the primary vehicle used by the individual. This service shall

not include the purchase of or the general repair of vehicles.

j. The EM provider shall ensure that all work and products are delivered, installed, and in good working order prior to seeking reimbursement from DMAS. The date of service on this provider's claim shall be within the prior authorization approval dates, which may be prior to the completion date as long as the work commenced during the approval dates. The prior authorization shall not be modified to accommodate installation delays. All requests for cost changes (either increases or decreases) shall be submitted to DMAS or the DMAS-designated prior authorization contractor for revision to the previously issued prior authorization and must include justification and supporting documentation of medical needs.

k. EM exclusions.

(1) There shall be no duplication of EM services with the same residence such as multiple wheelchair ramps or multiple modifications to the same room.

(2) Adaptations or improvements to the primary home that shall be excluded are of general utility and are not of direct medical or remedial benefit to the waiver individual, such as, but not necessarily limited to, carpeting, flooring, roof repairs, central air conditioning or heating, general maintenance and repairs to a home, additions or maintenance of decks, maintenance/replacement or addition of sidewalks, driveways, carports, or adaptations that only increase the total square footage of the home.

(3) EM shall not be covered by Medicaid for general leisure or diversion items or those items that are recreational in nature or those items that may be used as an outlet for adaptive/maladaptive behavioral issues. Such noncovered items may include, but shall not necessarily be limited to, swing sets, playhouses, climbing walls, trampolines, protective matting or ground cover, sporting equipment or exercise equipment, such as special bicycles or tricycles.

(4) EM shall not be approved for Medicaid coverage when the waiver individual resides in a residential provider's facility program, such as sponsored homes and congregate residential and supported living settings. EM shall not be covered by Medicaid if, for example, the Fair Housing Act (42 USC § 3601 et seq.), the Virginia Fair Housing Law (§ 36-96.1 et seq. of the Code of Virginia) or the Americans with Disabilities Act (42 USC § 12101 et seq.) requires the modification and the payment for such modifications to be made by a third party.

(5) EM shall not include the costs of removal or disposal, or any other costs, of previously installed modifications, whether paid for by DMAS or any other source.

(6) Providers of EM shall not be the waiver individual's spouse, parent (natural, adoptive, legal guardians), other legal guardians, or conservator. Providers who supply EM to waiver individuals shall not perform assessments/consultations or write EM specifications for such individuals.

5. Personal care services as defined in 12VAC30-120-1700, shall be covered for individuals older than 21 years of age who have a demonstrated need for assistance with ADLs and IADLs and who have a trained primary caregiver for skilled PDN interventions during portions of their day. PC services shall be rendered by a provider who has a DMAS provider agreement to provide PC, home health care, or skilled PDN. Due to the complex medical needs of this waiver population and the need for 24-hour supervision, the trained primary caregiver shall be present in the home and rendering the required skilled services during the entire time that the PCA is providing nonskilled care.

a. PC services are either of a supportive or health-related nature and may include, but are not limited to, assistance with ADLs, community access (such as, but not necessarily limited to, going to medical appointments), monitoring of self-administration of medication or other medical needs, and monitoring of health status and physical condition. In order to receive PC, the individual must require assistance with ADLs. When specified in the POC, PC services may also include assistance with IADLs to include making or changing beds, and cleaning areas used by the individual. Assistance with IADLs must be essential to the health and welfare of the individual, rather than the individual's representative, as applicable.

(1) The unit of service for PC services shall be one hour. The hours that may be authorized by DMAS or the designated prior authorization contractor shall be based on the individual's need as documented in the individual's POC and assessed on the Technology Assisted Waiver Adult Aide Plan of Care (DMAS-97 T).

(2) Supervision of the waiver individual shall not be covered as part of the tech waiver personal care service.

(3) Individuals may have skilled PDN, PC, and skilled private duty nursing respite care in their plans of care but shall not be authorized to receive these services simultaneously.

b. PC services shall 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, with the exception of skilled nursing tasks that may be delegated in accordance with Part VIII (18VAC90-20-420 et seq.). The PCA may perform ADL functions such as assistance to the primary caregiver but shall not perform any nursing duties or roles except as

permitted by Part VIII (18VAC90-20-420 et seq.). At a minimum, the staff providing PC must have been certified through coursework as either PCAs or home health aides.

c. DMAS will pay for any PC services that the PC aide gives to individuals to assist them in preparing for school or when they return home. DMAS shall not pay for the PC aide to assist the individual with any functions related to the individual completing post-secondary school functions or for supervision time during school.

d. PC exclusions.

(1) Time spent driving the waiver individual shall not be reimbursed.

(2) Regardless of the combination of skilled PDN and PC hours, the total combined number of hours that shall be reimbursed by DMAS in a 24-hour day shall not exceed 16 hours.

(3) The consumer-directed services model shall not be covered for any services provided in the tech waiver.

(4) Spouses, parents (natural, adoptive, legal guardians), siblings, grandparents, grandchildren, adult children, other legal guardians, or any person living under the same roof with the individual shall not provide PC services for the purpose of Medicaid reimbursement for the waiver individual.

6. Transition services shall be covered two ways: (i) as defined at 12VAC30-120-1700 to provide for applicants to move from institutional placements to community private homes and shall be prior authorized by DMAS or the designated prior authorization contractor in order for reimbursement to occur, and (ii) for applicants who have already moved from an institution to the community within 30 days of their transition. The applicant's transition from an institution to the community shall be coordinated by the facility's discharge planning team. The discharge planner shall coordinate with the DMAS staff to ensure that technology assisted waiver eligibility criteria shall be met.

a. Transition services shall be prior authorized by DMAS or its designated prior authorization contractor in order for reimbursement to occur. These services shall include those set out in the MFP program.

b. For the purposes of transition funding, an institution means an ICF/MR, a specialized care nursing facility or a long-stay hospital as defined at 42 CFR 435.1009. Transition funding shall not be available for individuals who have been admitted to an acute care hospital.

c. When the Money Follows the Person demonstration waiver grant is terminated by federal action, the portion of this service covered through MFP shall also terminate. The remaining transition services shall continue until modified.

C. Changes to services or termination of services.

1. DMAS or its designated agent shall have the final authority to approve or deny a requested change to an individual's skilled PDN and PC hours. Any request for an increase to an individual's skilled PDN or PC hours that exceeds the number of hours allowed for that individual's LOC shall be prior authorized by DMAS staff and accompanied by adequate documentation justifying the increase.

a. The provider may decrease the amount of authorized care if the revised skilled PDN hours are appropriate and based on the needs of the individual. The provider agency shall work with the DMAS staff for coordination and final approval of any decrease in service delivery. A revised tech waiver skilled PDN authorization shall be completed by DMAS for final authorization and forwarded to the provider agency.

b. The provider shall be responsible for documenting in writing the physician's verbal orders and for inclusion of the changes on the recertification POC in accordance with the DMAS skilled PDN Authorization Form. The provider agency's RN supervisor, who is responsible for supervising the individual's care, shall use a person-centered approach in discussing the change in care with the individual and individual representative to include documentation in the individual's record. The DMAS staff or the DMAS designated prior authorization contractor shall notify in writing the individual or individual representative of the change.

c. The provider shall be responsible for submitting the DMAS-225 form to the local department of social services when the following situations occur: (i) when Medicaid eligibility status changes; (ii) when the individual's level of care changes; (iii) when the individual is admitted to or discharged from an institution, a home and community-based waiver, or a provider agency's care; (iv) the individual dies; or (v) any other information that causes a change in the individual's eligibility status or patient pay amounts.

2. At any time the individual no longer meets LOC criteria for the waiver, termination of waiver enrollment shall be initiated by DMAS staff who is assigned to the individual. In such instances, DMAS shall forward the DMAS-225 form to the local department of social services.

3. In an emergency situation when the health, safety, and welfare of the provider staff is endangered, the provider agency may immediately initiate discharge of the individual and contact the DMAS staff. The provider must issue written notification containing the reasons for and the effective date of the termination of services. The written notification period in subdivision 4 of this subsection shall not be required. Other entities (e.g., licensing authorities, APS, CPS) shall also be notified as appropriate. A copy of this letter shall be forwarded to the DMAS staff within five business days of the letter's date.

4. In a nonemergency situation (i.e., when the health, safety, or welfare of the waiver individual or provider personnel are not endangered), the provider shall provide the individual and individual representative 14 calendar days' written notification (plus three days to allow for mail transmission) of the intent to discharge the individual from agency services. Written notification shall provide the reasons for and the effective date of the termination of services as well as the individual's appeal rights. A copy of the written notification shall also be forwarded to the DMAS staff within five business days of the date of the notification.

5. Individuals who no longer meet the tech waiver criteria as certified by the physician for either children or adults shall be terminated from the waiver. In such cases, a reduction in skilled PDN hours may occur that shall not exceed two weeks in duration as long as such skilled PDN was previously approved in the individual's POC. The agency provider of skilled PDN for such individuals shall document with DMAS the decrease in skilled PDN hours and prepare for cessation of skilled PDN hours and waiver services.

6. When a waiver individual, regardless of age, requires admission to a specialized care nursing facility or long-stay hospital, the individual shall be discharged from waiver services while he is in the specialized care nursing facility or long-stay hospital. Readmission to waiver services may resume once the individual has been discharged from the specialized care nursing facility or long-stay hospital as along as the waiver eligibility and medical necessity criteria continue to be met. For individuals 21 years of age and older, the individual must follow the criteria for specialized care nursing facility admission. For individuals who are younger than 21 years of age, the individual must follow the criteria for long-stay hospital admissions as well as the age appropriate criteria.

7. When a waiver individual, regardless of age, requires admission to a rehabilitation hospital, the individual shall be discharged from waiver services while he is in the rehabilitation hospital. When such rehabilitation hospitalization exceeds 30 days, readmission to waiver services requires a reassessment by the PAS team for determination that the individual currently meets Medicaid eligibility, functional criteria, and specialized nursing facility waiver criteria. If these criteria are met, the individual shall be readmitted to waiver services. For adults, ages 21 years and older, the individual shall meet the criteria for specialized care admissions. For children, younger than 21 years of age, the individual shall meet the criteria for long-stay hospital admissions and the age appropriate criteria.

8. Waiver individuals, regardless of age, who require admission to any type of acute care facility for less than 30 days shall, upon discharge from such acute care facility, be eligible for waiver services as long as all other requirements continue to be met.

12VAC30-120-1730. General requirements for participating providers.

A. All agency providers shall sign the appropriate technology assisted waiver provider agreement in order to bill and receive Medicaid payment for services rendered. Requests for provider enrollment shall be reviewed by DMAS to determine whether the provider applicant meets the requirements for Medicaid participation and demonstrates the abilities to perform, at a minimum, the following activities:

1. Be able to render the medically necessary services required by the waiver individuals. Accept referrals for services only when staff is available and qualified to initiate and perform the required services on an ongoing basis;

2. Assure the individual's freedom to reject medical care and treatment;

3. Assure freedom of choice to individuals in seeking medical care from any institution, pharmacy, or practitioner qualified to perform the service or services that may be required and participating in the Medicaid program at the time the service or services are performed;

4. Actively involve the individual and the authorized representative, as applicable, in the assessment of needs, strengths, goals, preferences, and abilities and incorporate this information into the person-centered planning process. A provider shall protect and promote the rights of each individual for whom he is providing services and shall provide for each of the following individual rights:

a. The individual's rights are exercised by the person appointed under state law to act on the individual's behalf in the case of an individual adjudged incompetent under the laws of the Commonwealth by a court of competent jurisdiction,

b. The individual, who has not been adjudged incompetent by the state court, may designate any legal-surrogate in accordance with state law to exercise the individual's rights to the extent provided by state law.

c. The individual shall have the right to receive services from the provider with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other waiver individuals would be endangered.

5. Perform a criminal background check and sex offender registry checks on all employees, including the business owner, who may have any contact or provide services to the waiver individual. Such record checks shall include national searches as well as with the Virginia State Police for the Commonwealth. Searches shall also be made of the Virginia CPS Central Registry, adult protective services, the National Sex Offender Registry, and the Virginia Nurse Aide Registry.

a. Provider documentation of the results of these searches must be made available upon request of DMAS or its authorized representatives. Persons convicted of having committed barrier crimes as defined in § 32.1-162.9:1 of the Code of Virginia shall not render services to waiver individuals for the purposes of seeking Medicaid reimbursement.

b. Persons having founded dispositions in the CPS Central Registry at DSS shall not be permitted to render services to children in this waiver and seek Medicaid reimbursement. Medicaid reimbursement shall not be made for providers' employees who have findings in the Nurse Aide Registry with the Virginia Board of Nursing of the Department of Health Professions concerning abuse, neglect, or mistreatment of individuals or misappropriation of their property.

6. Screen all new and existing employees and contractors to determine whether any of them have been excluded from participation in federal programs. Search the HHS-OIG List of Excluded Individuals and Entities (LEIE) website monthly by name for employees, contractors and entities to validate the eligibility of such persons and entities for federal programs.

a. Immediately report to DMAS any exclusion information identified.

b. Such information shall be sent in writing and shall include the individual or business name, provider identification number (if applicable), and what, if any, action has been taken to date.

c. Such information shall be sent to: DMAS, ATTN: Program Integrity/Exclusions, 600 E. Broad St., Suite 1300, Richmond, VA 23219 or emailed to providerexclusion@dmas.virginia.gov.

7. Provide services and supplies to individuals in full compliance with Title VI of the Civil Rights Act of 1964, as amended (42 USC § 2000 et seq.), which prohibits discrimination on the grounds of race, color, religion, or national origin; the Virginians with Disabilities Act (§ 51.5-1 et seq. of the Code of Virginia); § 504 of the Rehabilitation Act of 1973, as amended (29 USC § 794), which prohibits discrimination on the basis of a disability; and the ADA of 1990, as amended (42 USC § 12101 et seq.), which provides comprehensive civil rights protections to individuals with disabilities.

8. Report all suspected violations, pursuant to § 63.2-1606 et seq. and §§ 63.2-1508 through 63.2-1513 of the Code of Virginia, involving mistreatment, neglect, or abuse, including injuries of an unknown source, and misappropriation of individual property to either CPS, APS, or other officials in accordance with state law. Providers shall also train their staff in recognizing all types of such injuries and how to report them to the appropriate authorities. Providers shall ensure that all employees are aware of the requirements to immediately report such suspected abuse, neglect, or exploitation to APS, CPS or human rights, as appropriate.

9. Notify DMAS or its designated agent immediately, in writing, of any change in the information that the provider previously submitted to DMAS. When ownership of the provider changes, notify DMAS at least 15 calendar days before the date of such a change;

10. Provide services and supplies to individuals in full compliance of the same quality and in the same mode of delivery as are provided to the general public. Submit charges to DMAS for the provision of services and supplies to individuals in amounts not to exceed the provider's usual and customary charges to the general public.

11. Accept as payment in full the amount established and reimbursed by DMAS' payment methodology beginning with individuals' authorization dates for the waiver services. The provider shall not attempt to collect from the individual or the individual's responsible relative or relatives any amount the provider may consider a balance due amount or an uncovered amount. Providers shall not collect balance due amounts from individuals or individuals' responsible relatives even if such persons are willing to pay such amounts. Providers shall not bill DMAS, individuals or their responsible relatives for broken or missed appointments.

12. Collect all applicable patient pay amounts pursuant to 12VAC30-40-20, 12VAC30-40-30, 12VAC30-40-40, 12VAC30-40-50, and 12VAC30-40-60.

13. Use only DMAS-designated forms for service documentation. The provider shall not alter the required DMAS forms in any manner unless DMAS' approval is obtained prior to using the altered forms.

14. Not perform any type of direct-marketing activities to Medicaid individuals.

15. Furnish access to individuals who are receiving Medicaid services and furnish information, on request and in the form requested, to DMAS or its designated agent or agents, the Attorney General of Virginia or his authorized representatives, the state Medicaid Fraud Control Unit, the State Long-Term Care Ombudsman and any other authorized state and federal personnel. The Commonwealth's right of access to individuals receiving services and to provider agencies and records shall survive any termination of the provider agreement.

16. Disclose, as requested by DMAS, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, and business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of services to participants of Medicaid.

17. Pursuant to 42 CFR 431.300 et seq. and § 32.1-325.3 of the Code of Virginia, all information associated with an

applicant or recipient that could disclose the individual's identity is confidential and shall be safeguarded. Access to information concerning applicants or recipients must be restricted to persons or agency representatives who are subject to the standards of confidentiality that are consistent with that of the agency, and any such access must be in accordance with the provisions found in 12VAC30-20-90.

18. Meet staffing, financial solvency, disclosure of ownership, assurance of comparability of services requirements, and other requirements as specified in the provider contract (Medical Assistance Program Participation Agreement).

19. Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the services provided fully and accurately with documentation necessary to support services billed. Failure to meet this requirement may result in DMAS' recovery of expenditures resulting from claims payment.

20. Maintain a medical record for each individual who is receiving waiver services. Failure to meet this requirement may result in DMAS recovering expenditures made for claims paid that are not adequately supported by the provider's documentation.

21. Retain business and professional records at least six years from the last date of service or as provided by applicable federal and state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records shall be retained until the audit is completed and every exception resolved. Policies regarding retention of records shall apply even if the provider discontinues operation. DMAS shall be notified in writing of the storage location and procedures for obtaining records for review should the need arise. The location, agent, or trustee shall be within the Commonwealth.

22. Retain records of minors for at least six years after such minor has reached 18 years of age.

23. Ensure that all documentation in the individual's record is completed, signed, and dated with the name or names of the person or persons providing the service and the appropriate title, dated with month, day, and year, and in accordance with accepted professional practice. This documentation shall include the nurses' or PCAs', as appropriate, arrival and departure times for each shift that is worked.

24. Begin PDN services for which it expects reimbursement only when the admission packet is received and DMAS' authorization for skilled PDN services has been given. This authorization shall include the enrollment date that must be issued by DMAS staff. It shall be the provider agency's responsibility to review and ensure the receipt of a complete and accurate screening packet.

25. Ensure that there is a backup caregiver who accepts responsibility for the oversight and care of the individual in order to assure the health, safety, and welfare of the individual when the primary caregiver is ill, incapacitated, or using PDN respite. Documentation in the medical record must include this backup caregiver's name and phone number.

26. Notify the DMAS staff every time the waiver individual's primary residence changes.

27. Ensure that minimum qualifications of provider staff are met as follows:

a. All employees shall have a satisfactory work record, as evidenced by at least two references from prior job experiences. In lieu of this requirement, employees who have only worked for one employer shall be permitted to provide two personal references.

b. Staff and agencies shall meet any certifications, licensure, or registration, as applicable and as required by applicable state law. Staff qualifications must be documented and maintained for review by DMAS or its designated agent. All additional provider requirements as may be required under a specific waiver service in this part must also be met.

c. In addition, the RN as well as all nurses providing the skilled PDN service shall be currently and validly licensed to practice nursing in the Commonwealth and have at least six months of related clinical experience which may include work in acute care hospitals, long-stay hospitals, rehabilitative hospitals or specialized care nursing facilities. The LPN shall be under the direct supervision of an RN.

d. The RN supervisor shall be currently licensed to practice nursing in the Commonwealth and have at least one year of related clinical nursing experience, which may include work in an acute care hospital, long-stay hospital, rehabilitation hospital, or specialized care nursing facility.

B. DMAS shall have the authority to require the submission of any other medical documentation or information as may be required to complete a decision for a waiver individual's eligibility, waiver enrollment, or coverage for services.

1. Review of individual-specific documentation shall be conducted by DMAS or its designated agent. This documentation shall contain, up to and including the last date of service, all of the following, as may be appropriate for the service rendered:

a. All supporting documentation, including physicians' orders, from any provider rendering waiver services for the individual;

b. All assessments, reassessments, and evaluations (including the complete UAI screening packet or risk evaluations) made during the provision of services, including any required initial assessments by the RN

supervisor completed prior to or on the date services are initiated and changes to the supporting documentation by the RN supervisor;

c. Progress notes reflecting individual's status and, as appropriate, progress toward the identified goals on the POC;

d. All related communication with the individual and the family/caregiver, the designated agent for prior authorization, consultants, DMAS, DSS, formal and informal service providers, referral to APS or CPS and all other professionals concerning the individual, as appropriate.

e. Prior-authorization decisions performed by the DMAS staff or the DMAS-designated prior authorization contractor;

f. All POCs completed for the individual and specific to the service being provided and all supporting documentation related to any changes in the POCs; and

g. Attendance logs documenting the date and times services were rendered, the amount and type of services rendered and the dated professional signature with title.

2. Review of provider participation standards and renewal of provider agreements. DMAS shall be responsible for assuring continued adherence to provider participation standards by conducting ongoing monitoring of compliance.

a. DMAS shall recertify each provider for agreement renewal, contingent upon the provider's timely license renewal, to provide home and community-based waiver services.

b. A provider's noncompliance with DMAS policies and procedures, as required in the provider agreement, may result in a written request from DMAS for a corrective action plan that details the steps the provider shall take and the length of time required to achieve full compliance with the corrective action plan which shall correct the cited deficiencies.

c. DMAS shall immediately terminate the provider's Medicaid provider agreement pursuant to § 32.1-325 of the Code of Virginia and as may be required for federal financial participation. A provider who has been convicted of a felony, or who has otherwise pled guilty to a felony, in Virginia or in any other of the 50 states, the District of Columbia, or the U.S. territories must, within 30 days of such conviction, notify DMAS of this conviction and relinquish its provider agreement. Such provider agreement terminations shall be immediate and conform to 12VAC30-10-690 and 12VAC30-20-491.

d. Providers shall not be reimbursed for services that may be rendered between the conviction of a felony and the provider's notification to DMAS of the conviction.

e. Except as otherwise provided by applicable state or federal law, the Medicaid provider agreement may be terminated at will on 30 days' written notice. The agreement may be terminated if DMAS determines that the provider poses a threat to the health, safety, or welfare of any individual enrolled in a DMAS administered program.

12VAC30-120-1740. Participation standards for provision of services.

A. Skilled PDN, skilled PDN respite, and PC services. DMAS or its designated agent shall periodically review and audit providers' records for these services for conformance to regulations and policies, and concurrence with claims that have been submitted for payment. When an individual is receiving multiple services, the records for all services shall be separated from those of nonhome and community-based care services, such as companion or home health services. The following documentation must be maintained for every individual for whom DMAS-enrolled providers render these services:

1. Physicians' orders for these services shall be maintained in the individual's record as well as at the individual's primary residence. All recertifications of the POC must be performed within the last five business days of each current 60-day period. The physician shall sign the recertification before Medicaid reimbursement shall occur;

2. All assessments, reassessments, and evaluations (including the complete UAI screening packet or risk evaluations) made during the provision of services, including any required initial assessments by the RN supervisor completed prior to or on the date services are initiated and changes to the supporting documentation by the RN supervisor;

3. Progress notes reflecting individual's status and, as appropriate, progress toward the identified goals on the POC;

4. All related communication with the individual and the individual representative, the DMAS designated agent for prior authorization, consultants, DMAS, DSS, formal and informal service providers, all required referrals, as appropriate, to APS or CPS and all other professionals concerning the individual;

5. All prior authorization decisions rendered by the DMAS staff or the DMAS-designated prior authorization contractor;

6. All POCs completed with the individual, or family/caregiver, as appropriate, and specific to the service being provided and all supporting documentation related to any changes in the POC;

7. Attendance logs documenting the date and times services were rendered, the amount and type of services rendered and the dated signatures of the professionals who rendered the specified care, with the professionals' titles. Copies of all nurses' records shall be subject to review by either state or federal Medicaid representatives or both.

Any required nurses' visit notes, PCA notes, and all dated contacts with service providers and during supervisory visits to the individual's home and shall include:

a. The private duty nurse's or PCA's daily visit note with arrival and departure times;

b. The RN, LPN, or PCA daily observations, care, and services that have been rendered, observations concerning the individual's physical and emotional condition, daily activities and the individual's response to service delivery; and

c. Observations about any other services, such as and not limited to meals-on-wheels, companion services, and home health services, that the participant may be receiving shall be recorded in these notes.

8. Provider's HIPAA release of information form;

9. All Long Term Care Communication forms (DMAS-225);

10. Documentation of rejection or refusal of services and potential outcomes resulting from the refusal of services communicated to the individual or the individual representative;

11. Documentation of all inpatient hospital or specialized care nursing facility admissions to include service interruption dates, the reason for the hospital or specialized care nursing facility admission, the name of the facility or facilities and primary caregiver notification when applicable including all communication to DMAS;

12. The RN, LPN, or PCA's and individual's, or individual's representative's weekly or daily, as appropriate, signatures, including the date, to verify that services have been rendered during that week as documented in the record. An employee providing services to the Tech Waiver individual cannot sign for the individual. If the individual is unable to sign the nurses' records, it must be documented in the record how or who will sign in the individual's place. An employee of the provider shall not sign for the individual unless he is a family member of the individual or legal guardian of the individual;

13. Contact notes or progress notes reflecting the individual's status; and

14. Any other documentation to support that services provided are appropriate and necessary to maintain the individual in the home and in the community.

B. In addition to meeting the general conditions and requirements for home and community-based services participating providers and PDN, respite, and PC services, providers must also meet the following requirements:

1. This service shall be provided through either a home health agency licensed or certified by the VDH for Medicaid participation and with which DMAS has a contract for either skilled PDN or congregate PDN or both;

2. Demonstrate a prior successful health care delivery;

3. Operate from a business office; and

4. Employ (or subcontract with) and directly supervise an RN or an LPN. The LPN and RN shall be currently licensed to practice in the Commonwealth and have at least six months of related clinical nursing experience, which may include work in an acute care hospital, long-stay hospital, rehabilitation hospital, or specialized care nursing facility.

5. As part of direct supervision, the RN supervisor shall make, at a minimum, a visit every 30 days to ensure both quality and appropriateness of PDN and PDN respite services, to assess the individual's and individual representative's satisfaction with the services being provided, to review the medication and treatments and to update and verify the most current physician signed orders are in the home.

a. The waiver individual shall be present when the supervisory visits are made;

b. At least every other visit shall be in the individual's primary residence;

c. When a delay occurs in the RN supervisor's visits because the individual is unavailable, the reason for the delay must be documented in the individual's record, and the visit shall occur as soon as the individual is available. Failure to meet this standard may result in DMAS' recovery of payments made.

d. Additional supervisory visits may be required under the following circumstances: (i) at the provider's discretion; (ii) at the request of the individual when a change in the individual's condition has occurred; (iii) any time the health, safety, or welfare of the individual could be at risk; and (iv) at the request of the DMAS staff.

6. When respite services are routine in nature and offered in conjunction with PC services, the RN supervisory visit conducted for PC may serve as the supervisory visit for respite services. However, the supervisor 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.

7. For this waiver, personal care services shall only be agency directed and provided by a DMAS-enrolled PC provider.

a. For DMAS-enrolled skilled PDN providers that also provide PC services, the provider shall employ or subcontract with and directly supervise an RN who will provide ongoing supervision of all PCAs. The supervising RN shall be currently licensed to practice nursing in the Commonwealth and have at least one year of related clinical nursing experience, which may include work in an acute care hospital, long-stay hospital,

rehabilitation hospital, or specialized care nursing facility.

b. In addition to meeting the general conditions and requirements for home and community-based services participating providers as specified elsewhere in this part, the provision of PC services shall also comply with the requirements of 12VAC30-120-930.

8. Skilled monthly supervisory reassessments shall be performed in accordance with regulations by the PDN agency provider. The agency RN supervisor shall complete the monthly assessment visit and submit the "Technology Assisted Waiver Supervisory Monthly Summary" form (DMAS-103) to DMAS for review by the sixth day of the month following the month when the visit occurred.

9. Failure of the provider to assure timely submission of the required assessments may result in retraction of all skilled PDN payments for the period of time of the delinquency.

C. Assistive technology and environmental modification.

1. All AT and EM services shall be provided by DMAS-enrolled DME providers who have a DMAS provider agreement to provide AT or EM.

2. AT and EM shall be covered in the least expensive, most cost-effective manner. The provider must document and justify why more cost-effective solutions cannot be used. DMAS and the DMAS-designated prior authorization contractor may request further documentation on the alternative cost-effective solutions as necessary.

3. The provider documentation requirements for AT and EM shall be as follows:

a. Written documentation setting out the medical necessity for these services regarding the need for service, the process and results of ensuring that the item is not covered by the State Plan as DME and supplies and that it is not available from a DME provider when purchased elsewhere and contacts with vendors or contractors of service and cost;

b. Documentation of any or all of the evaluation, design, labor costs or supplies by a qualified professional;

c. Documentation of the date services are rendered and the amount of service needed;

d. Any other relevant information regarding the device or modification;

e. Documentation in the medical record of notification by the designated individual or individual representative of satisfactory completion or receipt of the service or item;

f. Instructions regarding any warranty, repairs, complaints, or servicing that may be needed; and

g. Any additional cost estimates requested by DMAS.

7. The EM/AT provider shall maintain a copy of all building permits and all building inspections for modifications, as required by code. All instructions regarding any warranty, repairs, complaints, and servicing that may be needed and the receipt for any purchased goods or services. More than one cost estimate may be required.

8. Individuals who reside in rental property must obtain written permission from the property's owner before any EM shall be authorized by DMAS. This letter shall be maintained in the provider's record.

12VAC30-120-1750. Payment for services.

A. All skilled PDN services, skilled PDN respite care services, and PC services provided in the tech waiver shall be reimbursed at an hourly rate established by DMAS.

B. Reimbursement for AT and EM shall be as follows.

1. All AT covered procedure codes provided in the tech waiver shall be reimbursed as a service limit of one and up to a per member annual maximum of $5,000 per calendar year regardless of waiver. Such service shall only be provided to individuals who are also receiving private duty nursing.

2. All EM services shall be reimbursed up to $5,000 per individual per calendar regardless of waiver year as long as such services are not duplicative. All EM services shall be reimbursed at the actual cost of material and labor and no mark ups shall be permitted. Such service shall only be provided to individuals who are also receiving private duty nursing.

C. Duplication of services.

1. DMAS shall not duplicate services that are required as a reasonable accommodation as a part of the ADA (42 USC §§ 12131 through 12165), the Rehabilitation Act of 1973 (29 USC 791 et seq.), or the Virginians with Disabilities Act (§ 51.5-1 et seq. of the Code of Virginia).

2. Payment for services under the POC shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. All private insurance benefits for skilled PDN shall be exhausted before Medicaid reimbursement can occur as Medicaid shall be the payer of last resort.

3. DMAS payments for EM shall not be duplicative in homes where multiple waiver individuals reside. For example, one waiver individual may be approved for required medically necessary bathroom modifications while a second waiver individual in the same household would be approved for a medically necessary access ramp but not additional improvements to the same bathroom.

D. Cost-effectiveness computations for the tech waiver shall be completed by DMAS upon completion of the POC for all individuals entering the waiver. The total annual aggregate cost of the waiver shall not exceed the cost of backup facility placement. For individuals, regardless of age, the DMAS staff shall ensure the anticipated cost to DMAS for the individual's waiver services for a 12-month period shall not exceed the annual average aggregate costs to DMAS for specialized

nursing facility care for those individual's 21 years of age or older or for continued hospitalization for individuals younger than 21 years of age.

12VAC30-120-1760. Quality management review; utilization reviews; level of care (LOC) reviews.

A. DMAS shall perform quality management reviews for the purpose of assuring high quality of service delivery consistent with the attending physicians' orders, approved POCs, and prior authorized services for the waiver individuals. Providers identified as not rendering reimbursed services consistent with such orders, POCs, and prior authorizations shall be required to submit corrective action plans (CAPs) to DMAS for approval. Once approved, such CAPs shall be implemented to resolve the cited deficiencies.

B. If the DMAS staff determines, during any review or at any other time, that the waiver individual no longer meets cost-effectiveness standards or medical necessity criteria, then the DMAS staff, as appropriate, shall deny payment for such waiver individual. Such waiver individuals shall be discharged from the waiver.

C. Securing prior authorization shall not necessarily guarantee reimbursement pursuant to DMAS utilization review of waiver services.

D. DMAS shall perform annual quality assurance reviews for tech waiver enrollees. Once waiver enrollment occurs, the Level of Care Eligibility Re-determination audits (LOCERI) shall be performed at DMAS. This independent electronic calculation of eligibility determination is performed and communicated to the DMAS supervisor for tech waiver. Any failure for waiver eligibility requires higher level of review by the supervisor and may include a home visit by the DMAS staff.

12VAC30-120-1770. Appeals; provider and recipient.

A. Providers shall have the right to appeal actions taken by DMAS. Provider appeals shall be considered pursuant to § 32.1-325.1 of the Code of Virginia and the Virginia Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia) and DMAS regulations at 12VAC30-10-1000 and 12VAC30-20-500 through 12VAC30-20-560.

B. Individuals shall have the right to appeal actions taken by DMAS. Individuals' appeals shall be considered pursuant to 12VAC30-110-10 through 12VAC30-120-370. DMAS shall provide the opportunity for a fair hearing, consistent with 42 CFR Part 431, Subpart E.

C. The individual shall be advised in writing of such denial and of his right to appeal consistent with DMAS client appeals regulations 12VAC30-110-70 through 12VAC30-110-80.

NOTICE: The following forms used in administering the regulation have been filed by the agency. The forms are not being published; however, online users of this issue of the Virginia Register of Regulations may click on the name of a form with a hyperlink to access it. The forms are also available from the agency contact or may be viewed at the Office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Richmond, Virginia 23219.

FORMS (12VAC30-120)

Virginia Uniform Assessment Instrument (UAI) (1994).

Consent to Exchange Information, DMAS-20 (rev. 4/03).

Provider Aide/LPN Record Personal/Respite Care, DMAS-90 (rev. 12/02).

LPN Skilled Respite Record, DMAS-90A (eff. 7/05).

Personal Assistant/Companion Timesheet, DMAS-91 (rev. 8/03).

Questionnaire to Assess an Applicant's Ability to Independently Manage Personal Attendant Services in the CD-PAS Waiver or DD Waiver, DMAS-95 Addendum (eff. 8/00).

Medicaid Funded Long-Term Care Service Authorization Form, DMAS-96 (rev. 10/06).

Screening Team Plan of Care for Medicaid-Funded Long Term Care, DMAS-97 (rev. 12/02).

Provider Agency Plan of Care, DMAS-97A (rev. 9/02).

Consumer Directed Services Plan of Care, DMAS-97B (rev. 1/98).

Community-Based Care Recipient Assessment Report, DMAS-99 (rev. 4/03).

Consumer-Directed Personal Attendant Services Recipient Assessment Report, DMAS-99B (rev. 8/03).

MI/MR Level I Supplement for EDCD Waiver Applicants, DMAS-101A (rev. 10/04).

Assessment of Active Treatment Needs for Individuals with MI, MR, or RC Who Request Services under the Elder or Disabled with Consumer-Direction Waivers, DMAS-101B (rev. 10/04).

AIDS Waiver Evaluation Form for Enteral Nutrition, DMAS-116 (6/03).

~~Medicaid Long Term Care Communication Form, DMAS-225 (3/09).~~

Medicaid Long Term Care Communication Form, DMAS-225 (rev. 10/11).

Technology Assisted Waiver/EPSDT Nursing Services Provider Skills Checklist for Individuals Caring for Tracheostomized and/or Ventilator Assisted Children and Adults, DMAS-259.

Home Health Certification and Plan of Care, CMS-485 (rev. 2/94).

IFDDS Waiver Level of Care Eligibility Form (eff. 5/07).

Technology Assisted Waiver Adult Aide Plan of Care, DMAS 97 T (rev. 6/08).

Technology Assisted Waiver Supervisory Monthly Summary, DMAS 103 (rev. 4/08).

Technology Assisted Waiver Adult Referral, DMAS 108 (rev. 3/10).

Technology Assisted Waiver Pediatric Referral, DMAS 109 (rev. 3/10).

Medicaid Long Term Care Communication Form, DMAS-225 (rev. 10/11).

DOCUMENTS INCORPORATED BY REFERENCE

User's Guide: Mental Retardation: Definition, Classification and Systems of Supports, 10th Edition, 2002, American Association on Intellectual and Developmental Disabilities.

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

Underwriter's Laboratories Safety Standard 1635, Standard for Digital Alarm Communicator System Units, Third Edition, January 31, 1996, with revisions through August 15, 2005.

Underwriter's Laboratories Safety Standard 1637, Standard for Home Health Care Signaling Equipment, Fourth Edition, December 29, 2006.

PDN Authorization.

Medical Assistance Program Participation Agreement.

VA.R. Doc. No. R09-597; Filed October 24, 2012, 3:08 p.m.

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARD OF FUNERAL DIRECTORS AND EMBALMERS

Final Regulation

REGISTRAR'S NOTICE: The Board of Funeral Directors and Embalmers is claiming an exemption from the Administrative Process Act in accordance with § 2.2-4006 A 3, which excludes regulations that consist only of changes in style or form or corrections of technical errors. The Board of Funeral Directors and Embalmers will receive, consider, and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: **18VAC65-30. Regulations for Preneed Funeral Planning (amending 18VAC65-30-60).**

Statutory Authority: §§ 54.1-2400, 54.1-2803, and 54.1-2820 of the Code of Virginia.

Effective Date: December 19, 2012.

Agency Contact: Lisa Russell Hahn, Executive Director, Board of Funeral Directors and Embalmers, 9960 Mayland Drive, Suite 300, Richmond, VA 23233-1463, telephone (804) 367-4424, FAX (804) 527-4637, or email lisa.hahn@dhp.virginia.gov.

Summary:

The amendment corrects a technical error to a Code of Virginia citation. The regulation should reference § 54.1-2820 C of the Code of Virginia, which pertains to contracts funded by insurance or annuity contracts.

Part III
Operational Responsibilities

18VAC65-30-60. Records; general.

A. A licensee shall keep accurate accounts, books, and records of all transactions required by this chapter.

B. Preneed contracts and reporting documents shall be retained on the premises of the establishment for one year after the death of the contract beneficiary.

C. A funeral home shall keep on file a written verification from the insurance company that the insurance or annuity contract complies with ~~§ 54.1-2820 B~~ § 54.1-2820 C of the Code of Virginia.

D. All preneed records shall be available for inspection by the Department of Health Professions.

VA.R. Doc. No. R13-3452; Filed October 24, 2012, 12:00 p.m.

BOARD OF MEDICINE

Proposed Regulation

Title of Regulation: **18VAC85-50. Regulations Governing the Practice of Physician Assistants (amending 18VAC85-50-10, 18VAC85-50-101, 18VAC85-50-110, 18VAC85-50-115, 18VAC85-50-130, 18VAC85-50-150).**

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

Public Hearing Information:

December 6, 2012 - 8:30 a.m. - Department of Health Professions, 9960 Mayland Drive, Perimeter Center, Suite 201, Richmond, VA

Public Comment Deadline: January 18, 2013.

Agency Contact: William L. Harp, M.D., Executive Director, Board of Medicine, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4558, FAX (804) 527-4429, or email william.harp@dhp.virginia.gov.

Basis: Section 54.1-2400 of the Code of Virginia provides the Board of Medicine the authority to promulgate regulations to administer the regulatory system. Specific authority for regulation of physician assistant practice is found in §§ 54.1-2951.1 and 54.1-2952 of the Code of Virginia.

Purpose: In its request for amendments, the Virginia Academy of Physician Assistants (VAPA) noted that the regulation currently restricts the practice of a physician with his physician assistant (PA) by mandating the exact number of successive visits each patient may receive from the PA. The rule may negatively impact scheduling of patients and the care and treatment of chronic illnesses. According to the VAPA, it would be preferable for the supervising physician to determine the frequency of review of PA services and the

frequency of seeing patients with continuing illnesses, depending on his medical judgment and knowledge of the patient. Since the physician is ultimately responsible for coordinating and managing the care of the patient, amendments to the supervisory responsibilities of a physician will provide appropriate oversight and evaluation to protect the health and safety of patients being jointly treated by PA's and supervising physicians.

Substance: The amendments require the supervising physician to review the clinical course and treatment plan for any patient who presents for the same acute complaint twice in a single episode of care and has failed to improve as expected. The supervising physician shall be involved with any patient with a continuing illness as noted in the PA/Physician Protocol for the evaluation process.

In the process of considering amendments to the "fourth visit," the board also amended its current regulations for prescriptive authority for PA's to ensure compliance with §§ 54.1-2952 and 54.1-2952.1 of the Code of Virginia, which requires a written agreement setting out the controlled substances (by schedule or class of drugs) the PA is allowed to prescribe and requirements for site visits if the PA practices in a location other than where the supervising physician regularly practices.

Issues: The advantage of the amended regulation is more flexibility in the scheduling of patients with the supervising physician or the PA, while specifying that the physician must be involved with a patient for a continuous illness or see the patient who presents for the same complaint twice in a single episode and has not improved. Greater specificity in the content of a practice agreement with delineation of roles and responsibilities is beneficial to practitioners and patients. There are no disadvantages to the public. There are no advantages or disadvantages to the Commonwealth.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The Board of Medicine (Board) proposes to amend its Regulations Governing the Practice of Physician Assistants to eliminate language that requires supervising physicians to see returning patients "not less frequently than every fourth visit for a continuing illness."

Result of Analysis. Benefits likely outweigh costs for implementing these proposed changes.

Estimated Economic Impact. Current regulations require that physicians who supervise physician assistants "see and evaluate" returning patients who are being treated for an ongoing health issue "not less frequently than every fourth visit." The Board believes this rule is too restrictive on physicians and physician assistants and may adversely impact patients, particularly patients with chronic illnesses, who may not be able to as easily schedule doctor's appointments at times that are convenient and at intervals that are conducive to maintaining treatment for their illnesses. The Board proposes to eliminate this requirement and, instead, require that the written practice agreement between physician assistants and their supervising physicians specify when a physician would step in to evaluate a patient. For instance, such an agreement might specify that the physician would reevaluate a patient if his or her symptoms changed or worsened.

This change will benefit physicians and physician assistants who will have more flexibility to plan office hours and patient visits more efficiently. The delineation of duties that will be written into the practice agreements between these parties will likely protect quality of patient care so patients will likely not incur any costs on account of these changes. Patients may, instead, benefit if these changes allow them to more easily schedule appointments.

Businesses and Entities Affected. The Department of Health Professions (DHP) reports that the Board currently regulates 1,781 physician assistants. All of these individuals, as well as their supervisors and patients will be affected by these proposed regulations.

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

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

Effects on the Use and Value of Private Property. These proposed regulatory changes are unlikely to affect the use or value of private property in the Commonwealth.

Small Businesses: Costs and Other Effects. No small business is likely to incur any costs on account of this regulatory action.

Small Businesses: Alternative Method that Minimizes Adverse Impact. No small business is likely to incur any costs on account of this regulatory action.

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

Legal Mandate. The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007.04 of the Administrative Process Act and Executive Order Number 14 (10). Section 2.2-4007.04 requires that such economic impact analyses include, but need not be limited to, the projected number of businesses or other entities to whom the regulation would apply, the identity of any localities and types of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or entities to implement or comply with the regulation, and the impact on the use and value of private property. Further, if the proposed regulation has adverse effect on small businesses, § 2.2-4007.04 requires that such economic impact analyses include (i) an identification and estimate of the number of small

businesses subject to the regulation; (ii) the projected reporting, recordkeeping, and other administrative costs required for small businesses to comply with the regulation, including the type of professional skills necessary for preparing required reports and other documents; (iii) a statement of the probable effect of the regulation on affected small businesses; and (iv) a description of any less intrusive or less costly alternative methods of achieving the purpose of the regulation. The analysis presented above represents DPB's best estimate of these economic impacts.

Agency's Response to Economic Impact Analysis: The Board of Medicine concurs with the analysis of the Department of Planning and Budget for 18VAC85-50, Regulations Governing the Practice of Physician Assistants, relating to practice agreements.

Summary:

The amendments (i) change the requirement for the physician to see a patient not less frequently than every fourth visit for a continuing illness by allowing the physician and his assistant to determine the evaluation process and (ii) amend the regulations for consistency and clarity.

Part I
General Provisions

18VAC85-50-10. Definitions.

A. The following words and terms shall have the meanings ascribed to them in § 54.1-2900 of the Code of Virginia:

"Board."

"Physician assistant."

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

"Committee" means the Advisory Committee on Physician Assistants as specified in § 54.1-2950.1of the Code of Virginia.

"Group practice" means the practice of a group of two or more doctors of medicine, osteopathy, or podiatry licensed by the board who practice as a partnership or professional corporation.

"Institution" means a hospital, nursing home or other health care facility, community health center, public health center, industrial medicine or corporation clinic, a medical service facility, student health center, or other setting approved by the board.

"NCCPA" means the National Commission on Certification of Physician Assistants.

~~"Protocol"~~ "Practice agreement" means a ~~set of directions~~ written agreement developed by the supervising physician that defines the supervisory relationship between the physician assistant and the physician and the circumstances under which the physician will see and evaluate the patient.

"Supervision" means:

1. "Alternate supervising physician" means a member of the same group or professional corporation or partnership of any licensee, any hospital or any commercial enterprise with the supervising physician. Such alternating supervising physician shall be a physician licensed in the Commonwealth who has registered with the board and who has accepted responsibility for the supervision of the service that a physician assistant renders.

2. "Direct supervision" means the physician is in the room in which a procedure is being performed.

3. "General supervision" means the supervising physician is easily available and can be physically present or accessible for consultation with the physician assistant within one hour.

4. "Personal supervision" means the supervising physician is within the facility in which the physician's assistant is functioning.

5. "Supervising physician" means the doctor of medicine, osteopathy, or podiatry licensed in the Commonwealth who has accepted responsibility for the supervision of the service that a physician assistant renders.

6. "Continuous supervision" means the supervising physician has on-going, regular communication with the physician assistant on the care and treatment of patients.

Part IV
Practice Requirements

18VAC85-50-101. Requirements for a ~~protocol~~ practice agreement.

A. Prior to initiation of practice, a physician assistant and his supervising physician shall submit a written ~~protocol~~ practice agreement which spells out the roles and functions of the assistant. Any such ~~protocol~~ practice agreement shall take into account such factors as the physician assistant's level of competence, the number of patients, the types of illness treated by the physician, the nature of the treatment, special procedures, and the nature of the physician availability in ensuring direct physician involvement at an early stage and regularly thereafter. The ~~protocol~~ practice agreement shall also provide an evaluation process for the physician assistant's performance, including a requirement specifying the time period, proportionate to the acuity of care and practice setting, within which the supervising physician shall review the record of services rendered by the physician assistant.

B. The board may require information regarding the level of supervision, i.e. "direct," "personal" or "general," with which the supervising physician plans to supervise the physician assistant for selected tasks. The board may also require the supervising physician to document the assistant's competence in performing such tasks.

C. If the role of the assistant includes prescribing for drugs and devices, the written ~~protocol~~ practice agreement shall include ~~those~~:

1. Those schedules and categories of drugs and devices that are within the scope of practice and proficiency of the supervising physician.; and

2. Requirements for periodic site visits by supervising licensees who supervise and direct assistants who provide services at a location other than where the licensee regularly practices.

D. If the initial practice agreement did not include prescriptive authority, an addendum to the practice agreement for prescriptive authority shall be submitted.

E. If there are any changes in supervision, authorization, or scope of practice, a revised practice agreement shall be submitted at the time of the change.

18VAC85-50-110. Responsibilities of the supervisor.

The supervising physician shall:

1. ~~See and evaluate any patient who presents the same complaint twice in a single episode of care and has failed to improve significantly. Such physician involvement shall occur not less frequently than every fourth visit for a continuing illness~~ Review the clinical course and treatment plan for any patient who presents for the same acute complaint twice in a single episode of care and has failed to improve as expected. The supervising physician shall be involved with any patient with a continuing illness as noted in the written practice agreement for the evaluation process.

2. Be responsible for all invasive procedures.

a. Under general supervision, a physician assistant may insert a nasogastric tube, bladder catheter, needle, or peripheral intravenous catheter, but not a flow-directed catheter, and may perform minor suturing, venipuncture, and subcutaneous intramuscular or intravenous injection.

b. All other invasive procedures not listed above must be performed under direct supervision unless, after directly supervising the performance of a specific invasive procedure three times or more, the supervising physician attests to the competence of the physician assistant to perform the specific procedure without direct supervision by certifying to the board in writing the number of times the specific procedure has been performed and that the physician assistant is competent to perform the specific procedure. After such certification has been accepted and approved by the board, the physician assistant may perform the procedure under general supervision.

3. Be responsible for all prescriptions issued by the assistant and attest to the competence of the assistant to prescribe drugs and devices.

18VAC85-50-115. Responsibilities of the physician assistant.

A. The physician assistant shall not render independent health care and shall:

1. Perform only those medical care services that are within the scope of the practice and proficiency of the supervising physician as prescribed in the physician assistant's ~~protocol~~ practice agreement. When a physician assistant is to be supervised by an alternate supervising physician outside the scope of specialty of the supervising physician, then the physician assistant's functions shall be limited to those areas not requiring specialized clinical judgment, unless a separate ~~protocol~~ practice agreement for that alternate supervising physician is approved and on file with the board.

2. Prescribe only those drugs and devices as allowed in Part V (18VAC85-50-130 et seq.) of this chapter.

3. Wear during the course of performing his duties identification showing clearly that he is a physician assistant.

B. If, due to illness, vacation, or unexpected absence, the supervising physician is unable to supervise the activities of his assistant, such supervising physician may temporarily delegate the responsibility to another doctor of medicine, ~~osteopathy~~ osteopathic medicine, or podiatry. The supervising physician so delegating his responsibility shall report such arrangement for coverage, with the reason therefor, to the board office in writing, subject to the following provisions:

1. For planned absence, such notification shall be received at the board office at least one month prior to the supervising physician's absence;

2. For sudden illness or other unexpected absence, the board office shall be notified as promptly as possible, but in no event later than one week; and

3. Temporary coverage may not exceed four weeks unless special permission is granted by the board.

C. With respect to assistants employed by institutions, the following additional regulations shall apply:

1. No assistant may render care to a patient unless the physician responsible for that patient has signed the ~~protocol~~ practice agreement to act as supervising physician for that assistant. The board shall make available appropriate forms for physicians to join the ~~protocol~~ practice agreement for an assistant employed by an institution.

2. Any such ~~protocol~~ practice agreement as described in subdivision 1 of this subsection shall delineate the duties which said physician authorizes the assistant to perform.

3. The assistant shall, as soon as circumstances may dictate, report an acute or significant finding or change in clinical status to the supervising physician concerning the examination of the patient. The assistant shall also record his findings in appropriate institutional records.

D. Practice by a physician assistant in a hospital, including an emergency department, shall be in accordance with § 54.1-2952 of the Code of Virginia.

Part V
Prescriptive Authority

18VAC85-50-130. Qualifications for approval of prescriptive authority.

An applicant for prescriptive authority shall meet the following requirements:

1. Hold a current, unrestricted license as a physician assistant in the Commonwealth;

2. Submit a ~~protocol~~ practice agreement acceptable to the board prescribed in 18VAC85-50-101. This ~~protocol~~ practice agreement must be approved by the board prior to issuance of prescriptive authority;

3. Submit evidence of successful passing of the NCCPA exam; and

4. Submit evidence of successful completion of a minimum of 35 hours of acceptable training to the board in pharmacology.

18VAC85-50-150. ~~Protocol regarding prescriptive authority.~~ (Repealed.)

~~A. A physician assistant with prescriptive authority may prescribe only within the scope of the written protocol as prescribed in 18VAC85-50-101.~~

~~B. A new protocol must be submitted with the initial application for prescriptive authority and with the application for each biennial renewal, if there have been any changes in supervision, authorization or scope of practice.~~

VA.R. Doc. No. R11-2642; Filed October 22, 2012, 12:01 p.m.

BOARD OF VETERINARY MEDICINE

Fast-Track Regulation

Title of Regulation: **18VAC150-20. Regulations Governing the Practice of Veterinary Medicine (amending 18VAC150-20-140, 18VAC150-20-172).**

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

Public Hearing Information: No public hearings are scheduled.

Public Comment Deadline: December 19, 2012.

Effective Date: January 3, 2013.

Agency Contact: Leslie L. Knachel, Executive Director, Board of Veterinary Medicine, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4468, FAX (804) 527-4471, or email leslie.knachel@dhp.virginia.gov.

Basis: Section 54.1-2400 of the Code of Virginia establishes the general powers and duties of health regulatory boards including the responsibility of the Board of Veterinary Medicine to promulgate regulations and administer a licensure and renewal program.

Purpose: The purpose of the amended regulation is to establish grounds for a finding of unprofessional conduct that involves fraud, deceit, or misrepresentation. Currently, there is no such provision, which has resulted in an inability to appropriately address complaints against veterinarians in a few cases. The purpose of the amendment is to ensure the health and safety of citizens by establishing board authority to take a disciplinary action in cases where there clearly has been fraud, deceit, or misrepresentation to the board or to a client, or both.

Rationale for Using Fast-Track Process: This regulation is appropriate for the fast-track process because there is no disagreement about whether the board should have authority to take disciplinary action for fraud, deceit, or misrepresentation. There is no controversy in clearly specifying the board's authority or in clarifying the ability to delegate veterinary tasks.

Substance: An amendment to regulations establishing grounds for unprofessional conduct (18VAC150-20-140) is adopted to include committing an act constituting fraud, deceit, or misrepresentation in dealing with the board or in the veterinarian-client-patient relationship. An amendment to 18VAC150-20-172 on delegation of duties by a veterinarian is adopted to clarify that the delegation may occur by any means, either electronically, in writing, or in person.

Issues: The primary advantage to the public would be the ability of the board to discipline a licensee who is found guilty of fraud, deceit, or misrepresentation to the board or to his clients. There are no disadvantages to the public, which is better protected if the board has authority to act in such cases.

There are no advantages or disadvantages to the agency.

Department of Planning and Budget's Economic Impact Analysis:

Summary of the Proposed Amendments to Regulation. The Board of Veterinary Medicine (Board) proposes 1) to add committing fraud, deceit, or misrepresentation in dealing with the Board or with the customers as grounds for unprofessional conduct and 2) to clarify that delegation of veterinarian duties can be done in writing or in person in addition to delegation by electronic means.

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

Estimated Economic Impact. The Board of Veterinary Medicine (Board) proposes to add committing fraud, deceit, or misrepresentation in dealing with the Board or with the customers as grounds for unprofessional conduct. According to Department of Health Professions (DHP), the Board currently does not have authority to take action against licensed veterinarians if they commit fraud, deceit, or misrepresentation in dealing with the Board or with the customers unless the fraud, deceit, or misrepresentation violates one of the other acts of unprofessional conduct listed in the regulations. The lack of authority is reported to have hindered the ability of the Board to appropriately address complaints against veterinarians in a few cases.

The main benefit of the proposed change is providing authority to the Board to take appropriate action against

veterinarians who commit fraud, deceit, or misrepresentation so that public health, safety, and/or welfare of citizens are better protected. In addition, the added authority is likely to discourage acts of fraud, deceit, or misrepresentation before they occur.

The main costs of this proposed change fall on the veterinarians who commit fraud, deceit, or misrepresentation since a disciplinary action may now be taken successfully against them. In such cases, the magnitude of the costs would depend on whether a pre-hearing consent is signed or a hearing is conducted. Depending on the seriousness of violation, the Board may levy a monetary penalty or impose a sanction.

Also, another proposed change clarifies that a veterinarian may delegate duties verbally or in writing in addition to delegation by electronic means. Since this change is a mere clarification of an existing standard, no significant economic effects are expected other than improving the clarity of the language and preventing a potentially costly misunderstanding.

Businesses and Entities Affected. There were 3,720 licensed veterinarians in Virginia at the end of 2010. However, no more than a few fraud, deceit, or misrepresentation cases are expected.

Localities Particularly Affected. The proposed regulations apply throughout the Commonwealth.

Projected Impact on Employment. The proposed regulations are not expected to have a significant impact on employment unless the license of a veterinarian is revoked upon violation of the new standard. In such cases, the supply of veterinarian services would be reduced.

Effects on the Use and Value of Private Property. The proposed regulations are not expected to have a significant impact on the use and value of private property unless a significant penalty including a license revocation levied or imposed on a veterinarian. In such cases, the asset value of the veterinarian practice may be reduced.

Small Businesses: Costs and Other Effects. While most of the regulated veterinarian establishments are believed to be small businesses, the proposed regulations are not expected to create significant costs or other effects on small businesses unless a significant penalty including a license revocation levied or imposed.

Small Businesses: Alternative Method that Minimizes Adverse Impact. There is no known alternative that minimizes potential adverse impact while accomplishing the same goals.

Real Estate Development Costs. The proposed regulations are not expected to create any real estate development costs.

Legal Mandate. The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007.04 of the Administrative Process Act and Executive Order Number 14 (10). Section 2.2-4007.04 requires that such economic impact analyses include, but need not be limited to, the projected number of businesses or other entities to whom the regulation would apply, the identity of any localities and types of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or entities to implement or comply with the regulation, and the impact on the use and value of private property. Further, if the proposed regulation has adverse effect on small businesses, § 2.2-4007.04 requires that such economic impact analyses include (i) an identification and estimate of the number of small businesses subject to the regulation; (ii) the projected reporting, recordkeeping, and other administrative costs required for small businesses to comply with the regulation, including the type of professional skills necessary for preparing required reports and other documents; (iii) a statement of the probable effect of the regulation on affected small businesses; and (iv) a description of any less intrusive or less costly alternative methods of achieving the purpose of the regulation. The analysis presented above represents DPB's best estimate of these economic impacts.

Agency's Response to Economic Impact Analysis: The Board of Veterinary Medicine concurs with the analysis of the Department of Planning and Budget for the proposed fast-track action on unprofessional conduct in 18VAC150-20, Regulations Governing the Practice of Veterinary Medicine.

Summary:

The amendments establish grounds for unprofessional conduct to include committing an act constituting fraud, deceit, or misrepresentation in dealing with the board or in the veterinarian-client-patient relationship and clarify that delegation of duties by a veterinarian may occur by any means, either electronically, in writing, or in person.

Part III
Unprofessional Conduct

18VAC150-20-140. Unprofessional conduct.

Unprofessional conduct as referenced in § 54.1-3807(5) of the Code of Virginia shall include the following:

1. Representing conflicting interests except by express consent of all concerned given after a full disclosure of the facts. Acceptance of a fee from both the buyer and the seller is prima facie evidence of a conflict of interest.

2. Practicing veterinary medicine or equine dentistry where an unlicensed person has the authority to control the professional judgment of the licensed veterinarian or the equine dental technician.

3. Issuing a certificate of health unless he shall know of his own knowledge by actual inspection and appropriate tests of the animals that the animals meet the requirements for the issuance of such certificate on the day issued.

4. Revealing confidences gained in the course of providing veterinary services to a client, unless required by law or

necessary to protect the health, safety or welfare of other persons or animals.

5. Advertising in a manner which is false, deceptive, or misleading or which makes subjective claims of superiority.

6. Violating any state law, federal law, or board regulation pertaining to the practice of veterinary medicine, veterinary technology or equine dentistry.

7. Practicing veterinary medicine or as an equine dental technician in such a manner as to endanger the health and welfare of his patients or the public, or being unable to practice veterinary medicine or as an equine dental technician with reasonable skill and safety.

8. Performing surgery on animals in an unregistered veterinary establishment or not in accordance with the establishment permit or with accepted standards of practice.

9. Refusing the board or its agent the right to inspect an establishment at reasonable hours.

10. Allowing unlicensed persons to perform acts restricted to the practice of veterinary medicine, veterinary technology or an equine dental technician including any invasive procedure on a patient or delegation of tasks to persons who are not properly trained or authorized to perform such tasks.

11. Failing to provide immediate and direct supervision to a licensed veterinary technician or an assistant in his employ.

12. Refusing to release a copy of a valid prescription upon request from a client.

13. Misrepresenting or falsifying information on an application or renewal form.

14. Failing to report suspected animal cruelty to the appropriate authorities.

15. Failing to release patient records when requested by the owner; a law-enforcement entity; or a federal, state, or local health regulatory agency.

16. Committing an act constituting fraud, deceit, or misrepresentation in dealing with the board or in the veterinarian-client-patient relationship.

18VAC150-20-172. Delegation of duties.

A. A licensed veterinarian may delegate the administration (including by injection) of schedule VI drugs to a properly trained assistant under his immediate and direct supervision. The prescribing veterinarian has a specific duty and responsibility to determine that the assistant has had adequate training to safely administer the drug in a manner prescribed. Injections involving anesthetic or chemotherapy drugs, subgingival scaling, or the placement of intravenous catheters shall not be delegated to an assistant.

B. Additional tasks that may be delegated by a licensed veterinarian to a properly trained assistant include but are not limited to the following:

1. Grooming;

2. Feeding;

3. Cleaning;

4. Restraining;

5. Assisting in radiology;

6. Setting up diagnostic tests;

7. Prepping for surgery;

8. Dental polishing and scaling of teeth above the gum line (supragingival);

9. Drawing blood samples; or

10. Filling of schedule VI prescriptions under the direction of a veterinarian licensed in Virginia.

C. A licensed veterinarian may delegate duties electronically, verbally, or in writing to appropriate veterinary personnel provided the veterinarian has physically examined the patient within the previous 36 hours.

D. Animal massage or physical therapy may be delegated by a veterinarian to persons qualified by training and experience by an order from the veterinarian.

E. The veterinarian remains responsible for the duties being delegated and remains responsible for the health and safety of the animal.

VA.R. Doc. No. R13-2760; Filed October 22, 2012, 11:22 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: **22VAC40-740. Adult Protective Services (amending 22VAC40-740-40).**

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

Effective Date: December 19, 2012.

Agency Contact: Paige McCleary, Department of Social Services, Division of Family Services, 801 East Main Street, Richmond, VA 23219, telephone (804) 726-7536, FAX (804)

726-7895, TTY (800) 828-1120, or email paige.mccleary@dss.virginia.gov.

Summary:

The amendment is a result of recodified sections of the Code of Virginia by the 2012 Acts of Assembly. Section 37.2-1000 et seq. of Chapter 10 of Title 37.2 of the Code of Virginia is recodified to § 64.2-2000 et seq. of Chapter 20 of Title 64.2 of the Code of Virginia.

22VAC40-740-40. Assessment narrative and disposition.

A. An assessment narrative shall be required for all adult protective services investigations and shall be titled "Adult Protective Services Assessment Narrative." The narrative must address, but is not limited to, the following:

1. Allegations in the report or circumstances discovered during the investigation that meet the definitions of abuse, neglect or exploitation.

2. The extent to which the adult is physically, emotionally and mentally capable of making and carrying out decisions concerning his health and well-being.

3. The risk of serious harm to the adult.

4. The need for an immediate response by the adult protective services worker upon receipt of a valid report.

5. The ability to conduct a private interview with the alleged victim, the alleged perpetrator (if known) and any collateral contacts having knowledge of the case.

B. After investigating the report, the adult protective services worker must review and evaluate the facts collected and make a disposition as to whether the adult is in need of protective services and, if so, what services are needed.

C. The disposition that the adult needs protective services shall be based on the preponderance of evidence that abuse, neglect or exploitation has occurred or that the adult is at risk of abuse, neglect or exploitation.

D. Possible dispositions.

1. Needs protective services. This disposition shall be used when:

a. A review of the facts shows a preponderance of evidence that adult abuse, neglect or exploitation has occurred or is occurring;

b. A review of the facts shows a preponderance of evidence that the adult is at risk of abuse, neglect or exploitation and needs protective services in order to reduce that risk;

c. The adult consents to receive services pursuant to § 63.2-1610 of the Code of Virginia; or

d. Involuntary services are ordered by the court pursuant to § 63.2-1609 or Article 1 ~~(§ 37.2-1000 et seq.) of Chapter 10 of Title 37.2~~ (§ 64.2-2000 et seq.) of Chapter 20 of Title 64.2 of the Code of Virginia.

2. Needs protective services and refuses. This disposition shall be used when:

a. A review of the facts shows a preponderance of evidence that adult abuse, neglect or exploitation has occurred or is occurring or the adult is at risk of abuse, neglect and exploitation; and

b. The adult refuses or withdraws consent to accept protective services pursuant to § 63.2-1610 of the Code of Virginia.

3. Need for protective services no longer exists. This disposition shall be used when the subject of the report no longer needs protective services. A review of the facts shows a preponderance of evidence that adult abuse, neglect or exploitation has occurred. However, at the time the investigation is initiated or during the course of the investigation, the adult who is the subject of the report ceases to be at risk of further abuse, neglect or exploitation.

4. Unfounded. This disposition shall be used when review of the facts does not show a preponderance of evidence that abuse, neglect or exploitation occurred or that the adult is at risk of abuse, neglect or exploitation.

E. The investigation shall be completed and a disposition assigned by the local department within 45 days of the date the report was received. If the investigation is not completed within 45 days, the record shall document reasons.

F. A notice of the completion of the investigation must be made in writing and shall be mailed to the reporter within 10 working days of the completion of the investigation.

G. The Adult Protective Services Program shall respect the rights of adults with capacity to consider options offered by the program and refuse services, even if those decisions do not appear to reasonably be in the best interests of the adult.

VA.R. Doc. No. R13-3365; Filed October 19, 2012, 10:04 a.m.

EXECUTIVE ORDER NUMBER 53 (2012)

Declaration of a State of Emergency for the Commonwealth of Virginia Due to the Threat of Hurricane Sandy Impacting Virginia

Importance of the Initiative

On October 26, 2012, I verbally declared a state of emergency to exist for the Commonwealth of Virginia based on National Hurricane Center and National Weather Service forecasts projecting impacts from Hurricane Sandy that could cause damaging high winds, periods of heavy rainfall, and coastal and lowland flooding throughout the Commonwealth.

The health and general welfare of the citizens require that state action be taken to help alleviate the conditions caused by this situation. The effects of this storm constitute a disaster wherein human life and public and private property are imperiled, as described in § 44-146.16 of the Code of Virginia.

Therefore, by virtue of the authority vested in me by § 44-146.17 of the Code of Virginia, as Governor and as Director of Emergency Management, and by virtue of the authority vested in me by Article V, Section 7 of the Constitution of Virginia and by § 44-75.1 of the Code of Virginia, as Governor and Commander-in-Chief of the armed forces of the Commonwealth, and subject always to my continuing and ultimate authority and responsibility to act in such matters, I hereby confirm, ratify, and memorialize in writing my verbal orders issued on this date, whereby I proclaimed that a State of Emergency exists and I direct that appropriate assistance be rendered by agencies of both state and local governments to prepare for potential impacts of the storm, to alleviate any conditions resulting from significant storm events and to implement recovery and mitigation operations and activities so as to return impacted areas to pre-event conditions in so far as possible. Pursuant to § 44-75.1(A)(3) and (A)(4) of the Code of Virginia, I also directed that a maximum of 750 members of the Virginia National Guard and the Virginia Defense Force be called forth to state duty to be prepared to assist in providing such aid. This shall include Virginia National Guard assistance to the Virginia State Police to direct traffic, prevent looting, and perform such other law enforcement functions as the Superintendent of State Police, in consultation with the State Coordinator of Emergency Management, the Adjutant General, and the Secretary of Public Safety, may find necessary.

In order to marshal all public resources and appropriate preparedness, response, and recovery measures to meet this potential threat and recover from its effects, and in accordance with my authority contained in § 44-146.17 of the Code of Virginia, I hereby order the following protective and restoration measures:

A. The implementation by agencies of the state and local governments of the Commonwealth of Virginia Emergency Operations Plan, as amended, along with other appropriate state agency plans.

B. The activation of the Virginia Emergency Operations Center (VEOC) and the Virginia Emergency Response Team (VERT) to coordinate the provision of assistance to local governments. I am directing that the VEOC and VERT coordinate state actions in support of potential affected localities, other mission assignments to agencies designated in the Commonwealth of Virginia Emergency Operations Plan (COVEOP), and others that may be identified by the State Coordinator of Emergency Management, in consultation with the Secretary of Public Safety, which are needed to provide for the preservation of life, protection of property, and implementation of recovery activities.

C. The authorization to assume control over the Commonwealth's state-operated telecommunications systems, as required by the State Coordinator of Emergency Management, in coordination with the Virginia Information Technology Agency, and with the consultation of the Secretary of Public Safety, making all systems assets available for use in providing adequate communications, intelligence, and warning capabilities for the event, pursuant to § 44-146.18 of the Code of Virginia.

D. The evacuation of areas threatened or stricken by effects of the storm. Following a declaration of a local emergency pursuant to § 44-146.21 of the Code of Virginia, if a local governing body determines that evacuation is deemed necessary for the preservation of life or other emergency mitigation, response or recovery, pursuant to § 44-146.17(1) of the Code of Virginia, I direct the evacuation of all or part of the populace therein from such areas and upon such timetable as the local governing body, in coordination with the Virginia Emergency Operations Center (VEOC), acting on behalf of the State Coordinator of Emergency Management, shall determine. I issued a mandatory evacuation order for low-lying areas along the Virginia coast and Chesapeake Bay, which grants local government officials authority to determine locations for evacuation and start times, based on local conditions. Specific evacuation orders will be issued by local governments. I reserve the right to direct and compel evacuation from the same and different areas and determine a different timetable both where local governing bodies have made such a determination and where local governing bodies have not made such a determination. Also, in those localities that have declared a local emergency pursuant to § 44-146.21 of the Code of Virginia, if the local governing body determines that controlling movement of persons is deemed necessary for the preservation of life, public safety, or other emergency mitigation, response, or recovery, pursuant to § 44-146.17(1) of the Code of Virginia, I authorize the control of ingress and egress at an emergency

area, including the movement of persons within the area and the occupancy of premises therein upon such timetable as the local governing body, in coordination with the State Coordinator of Emergency Management and the VEOC shall determine. Violations of these orders shall constitute a violation of this Executive Order and are punishable as a Class 1 misdemeanor.

E. The activation, implementation, and coordination of appropriate mutual aid agreements and compacts, including the Emergency Management Assistance Compact (EMAC), and the authorization of the State Coordinator of Emergency Management to enter into any other supplemental agreements, pursuant to §§ 44-146.17(5) and 44-146.28:1 of the Code of Virginia, to provide for the evacuation and reception of injured and other persons and the exchange of medical, fire, police, National Guard personnel and equipment, public utility, reconnaissance, welfare, transportation and communications personnel, and equipment and supplies. The State Coordinator of Emergency Management is hereby designated as Virginia's authorized representative within the meaning of the Emergency Management Assistance Compact, § 44-146.28:1 of the Code of Virginia.

F. The authorization of the Departments of State Police, Transportation, and Motor Vehicles to grant temporary overweight, over width, registration, or license exemptions to all carriers transporting essential emergency relief supplies, conducting essential emergency response operations or providing restoration of utilities (electricity, gas, phone, water, wastewater, and cable) in and through any area of the Commonwealth in order to support the disaster response and recovery, regardless of their point of origin or destination. Such exemptions shall not be valid on posted structures for restricted weight.

All over width loads, up to a maximum of 12 feet, and over height loads up to a maximum of 14 feet must follow Virginia Department of Motor Vehicles (DMV) hauling permit and safety guidelines.

In addition to described overweight/over width transportation privileges, carriers are also exempt from registration with the Department of Motor Vehicles. This includes vehicles in route and returning to their home base. The above-cited agencies shall communicate this information to all staff responsible for permit issuance and truck legalization enforcement.

Authorization of the State Coordinator of Emergency Management to grant limited exemption of hours of service worked by any carrier when transporting passengers, property, equipment, food, fuel, construction materials, and other critical supplies to or from any portion of the Commonwealth for purpose of providing direct relief or assistance as a result of this disaster, pursuant to § 52-8.4 of the Code of Virginia and Title 49, Code of Federal Regulations, §§ 390.23 and 395.3.

The foregoing overweight/over width transportation privileges as well as the regulatory exemption provided by § 52-8.4(A) of the Code of Virginia, and implemented in 19VAC30-20-40(B) of the "Motor Carrier Safety Regulations," shall remain in effect for 30 days from the onset of the disaster, or until emergency relief is no longer necessary, as determined by the Secretary of Public Safety in consultation with the Secretary of Transportation, whichever is earlier.

• The discontinuance of provisions authorized in paragraph F above may be implemented and disseminated by publication of administrative notice to all affected and interested parties by the authority I hereby delegate to the Secretary of Public Safety, after consultation with other affected Cabinet-level Secretaries.

• The authorization of a maximum of $250,000 for matching funds for the Individuals and Household Program, authorized by The Stafford Act (when presidentially authorized), to be paid from state funds.

• The implementation by public agencies under my supervision and control of their emergency assignments as directed in the COVEOP without regard to normal procedures pertaining to performance of public work, entering into contracts, incurring of obligations or other logistical and support measures of the Emergency Services and Disaster Laws, as provided in § 44-146.28(b) of the Code of Virginia. Section § 44-146.24 of the Code of Virginia also applies to the disaster activities of state agencies.

• The authorization of a maximum of $500,000 in state sum sufficient funds for state and local governments mission assignments authorized and coordinated through the Virginia Department of Emergency Management that are allowable as defined by The Stafford Act for gubernatorial and presidentially authorized events.

• Designation of members and personnel of volunteer, auxiliary, and reserve groups including search and rescue (SAR), Virginia Associations of Volunteer Rescue Squads (VAVRS), Civil Air Patrol (CAP), member organizations of the Voluntary Organizations Active in Disaster (VOAD), Radio Amateur Civil Emergency Services (RACES), volunteer fire fighters, Citizen Corps Programs such as Medical Reserve Corps (MRCs), Community Emergency Response Teams (CERTs), and others identified and tasked by the State Coordinator of Emergency Management for specific disaster related mission assignments as representatives of the Commonwealth engaged in emergency services activities within the meaning of the immunity provisions of § 44-146.23(a) and (f) of the Code of Virginia, in the

performance of their specific disaster-related mission assignments.

• The authorization of appropriate oversight boards, commissions, and agencies to ease building code restrictions and to permit emergency demolition, hazardous waste disposal, debris and refuse collection and removal, emergency landfill sitting, and operations and other activities necessary to address immediate health and safety needs without regard to time-consuming procedures or formalities and without regard to application or permit fees or royalties.

• The activation of the statutory provisions in § 59.1-525, et seq. of the Code of Virginia related to price gouging. Price gouging at any time is unacceptable. Price gouging is even more reprehensible after a natural disaster. I have directed all applicable executive branch agencies to take immediate action to address any verified reports of price gouging of necessary goods or services. I make the same request of the Office of the Attorney General and appropriate local officials.

• Pursuant to the authority granted to me under §§ 46.2-330, 46.2-345, and 44-146.24 of the Code of Virginia, I hereby order the Department of Motor Vehicles, and such other executive branch agencies as deem appropriate in their discretion, to extend the validity period of Virginia driver's licenses, special identification cards, permits, and other licenses or credentials issued by the Commonwealth that expire during the period from October 29th through November 8th of 2012 until November 9, 2012. I request that the Department of Motor Vehicles, and such other executive branch agencies as deem appropriate in their discretion, to waive any late fees associated with October registrations, licenses, permits, or credential renewals that are submitted on or before November 9, 2012. I further request that all appropriate executive branch agencies exercise their discretion to the extent allowed by law to address any other pending deadlines or expirations affected by or attributable to Hurricane Sandy.

• The following conditions apply to the deployment of the Virginia National Guard and the Virginia Defense Force:

1. The Adjutant General of Virginia, after consultation with the State Coordinator of Emergency Management, shall make available on state active duty such units and members of the Virginia National Guard and Virginia Defense Force and such equipment as may be necessary or desirable to assist in preparations and in alleviating the human suffering and damage to property.

2. Pursuant to § 52-6 of the Code of Virginia, I authorize the Superintendent of State Police to appoint any and all such Virginia Army and Air National Guard personnel called to state active duty as additional police officers as deemed necessary. These police officers shall have the same powers and perform the same duties as the State Police officers appointed by the Superintendent. However, they shall nevertheless remain members of the Virginia National Guard, subject to military command as members of the State Militia. Any bonds and/or insurance required by § 52-7 of the Code of Virginia shall be provided for them at the expense of the Commonwealth.

3. In all instances, members of the Virginia National Guard and Virginia Defense Force shall remain subject to military command as prescribed by § 44-78.1 of the Code of Virginia and not subject to the civilian authorities of county or municipal governments. This shall not be deemed to prohibit working in close cooperation with members of the Virginia Departments of State Police or Emergency Management or local law enforcement or emergency management authorities or receiving guidance from them in the performance of their duties.

4. Should service under this Executive Order result in the injury or death of any member of the Virginia National Guard, the following will be provided to the member and the member's dependents or survivors:

a. Workers' Compensation benefits provided to members of the National Guard by the Virginia Workers' Compensation Act, subject to the requirements and limitations thereof; and, in addition,

b. The same benefits, or their equivalent, for injury, disability, and/or death, as would be provided by the federal government if the member were serving on federal active duty at the time of the injury or death. Any such federal-type benefits due to a member and his or her dependents or survivors during any calendar month shall be reduced by any payments due under the Virginia Workers' Compensation Act during the same month. If and when the time period for payment of Workers' Compensation benefits has elapsed, the member and his or her dependents or survivors shall thereafter receive full federal-type benefits for as long as they would have received such benefits if the member had been serving on federal active duty at the time of injury or death. Any federal-type benefits due shall be computed on the basis of military pay grade E-5 or the member's military grade at the time of injury or death, whichever produces the greater benefit amount. Pursuant to § 44-14 of the Code of Virginia, and subject to the availability of future appropriations which may be lawfully applied to this purpose, I now approve of future expenditures out of appropriations to the Department of Military Affairs for such federal-type benefits as being manifestly for the benefit of the military service.

5. The following conditions apply to service by the Virginia Defense Force:

1. Compensation shall be at a daily rate that is equivalent of base pay only for a National Guard Unit Training

Assembly, commensurate with the grade and years of service of the member, not to exceed 20 years of service;

2. Lodging and meals shall be provided by the Adjutant General or reimbursed at standard state per diem rates;

3. All privately owned equipment, including, but not limited to, vehicles, boats, and aircraft, will be reimbursed for expense of fuel. Damage or loss of said equipment will be reimbursed, minus reimbursement from personal insurance, if said equipment was authorized for use by the Adjutant General in accordance with § 44-54.12 of the Code of Virginia; and

4. In the event of death or injury, benefits shall be provided in accordance with the Virginia Workers' Compensation Act, subject to the requirements and limitations thereof.

Upon my approval, the costs incurred by state agencies and other agents in performing mission assignments through the VEOC of the Commonwealth as defined herein and in § 44-146.28 of the Code of Virginia, other than costs defined in the paragraphs above pertaining to the Virginia National Guard and pertaining to the Virginia Defense Force, in performing these missions shall be paid from state funds.

Effective Date of the Executive Order

This Executive Order shall be effective retroactively to October 26, 2012, and shall remain in full force and effect until June 30, 2013, unless sooner amended or rescinded by further executive order. Termination of the Executive Order is not intended to terminate any federal-type benefits granted or to be granted due to injury or death as a result of service under this Executive Order.

Given under my hand and under the Seal of the Commonwealth of Virginia, this 30th day of October 2012.

/s/ Robert F. McDonnell
Governor

STATE AIR POLLUTION CONTROL BOARD

Notice of Periodic Review

Pursuant to Executive Order 14 (2010) and §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, the Department of Environmental Quality on behalf of the State Air Pollution Control Board will conduct a periodic review of 9VAC5-5, Public Participation Guidelines. The review of this regulation will be guided by the principles in Executive Order No. 14 (2010), Development and Review of Regulations Proposed by State Agencies, and § 2.2-4007.1 of the Administrative Process Act.

The purpose of the review is to determine whether the regulations should be terminated, amended or retained in their current form. The department and the board are seeking public comments on the review of any issue relating to the regulations including whether: (i) the regulations are effective in achieving their goals; (ii) the regulations are essential to protect the health, safety or welfare of citizens or for the economical performance of important governmental functions; (iii) there are available alternatives for achieving the purpose of the regulations; (iv) there are less burdensome and less intrusive alternatives for achieving the purpose of the regulations; and (v) the regulations are clearly written and easily understandable by the affected persons. In addition, the department and the board are seeking public comments on ways to minimize the economic impact on small businesses in a manner consistent with the purpose of the regulations. The purpose of this chapter is to promote public involvement in the development, amendment or repeal of the regulations of the State Air Pollution Control Board. Section 2.2-4007.02 of the Administrative Process Act (Chapter 40 of Title 2.2 of the Code of Virginia) requires that any agency required to adopt regulations must adopt public participation guidelines and specifies certain requirements that are to be included as part of these regulations. These regulations are designed with the least possible costs and intrusiveness to the citizens and businesses of the Commonwealth and to provide the necessary procedures and rules by which the statute may be administered.

The comment period begins November 19, 2012, and ends on December 10, 2012. Comments may be submitted to Debra A. Harris, Planning and Policy Specialist, Office of Regulatory Affairs, Department of Environmental Quality, Post Office Box 1105, Richmond, VA 23218 (deliveries can be made to 629 East Main Street, Richmond, VA 23219), telephone (804) 698-4209, FAX (804) 698-4346, or email debra.harris@deq.virginia.gov. Alternatively, comments may be submitted online to the Virginia Regulatory Town Hall at http://townhall.virginia.gov/L/Forums.cfm. Please note that comments must include the commenter's name and address (physical or email) in order to receive a response to the comment from the agency. Following the close of the public comment period, a report of the periodic review will be posted on the Town Hall and published in the Virginia Register of Regulations.

DEPARTMENT OF ENVIRONMENTAL QUALITY AND DEPARTMENT OF CONSERVATION AND RECREATION

Notice of Public Meeting and Public Comment

The Department of Environmental Quality (DEQ) and the Department of Conservation and Recreation (DCR) seek written and oral comments from interested persons on the development of a total maximum daily load implementation plan (TMDL IP) for the Spout Run, Page Brook and Roseville Run watersheds in Clarke County and the Towns of Millwood and Boyce. Spout Run was first listed as impaired on Virginia's 1998 § 303(d) TMDL Priority List and Report due to violations of the state's water quality standard for fecal coliform and the general standard (benthic) for aquatic life. Page Brook was added to the § 303(d) list for violations of the fecal coliform water quality standard in 2004, while Roseville Run was listed as impaired for violations of the bacteria standard for E. coli in 2010. The impaired segment of Spout Run (bacteria and benthic) extends from the confluence of Page Brook and Roseville Run to its confluence with the Shenandoah River (3.7 miles). The impaired segment of Page Brook begins at the creek's headwaters and extends down to its confluence with Roseville Run (8.78 miles). The impaired segment of Roseville Run extends the length of the stream, from the headwaters downstream to its confluence with Page Brook (3.94 miles).

Section 303(d) of the Clean Water Act and § 62.1-44.19:7 C of the Code of Virginia require DEQ to develop TMDLs for pollutants responsible for each impaired water contained in Virginia's § 303(d) TMDL Priority List and Report. In addition, § 62.1-44.19:7 C of the Code of Virginia requires the development of an IP for approved TMDLs. The IP should provide measurable goals and the date of expected achievement of water quality objectives. The IP should also include the corrective actions needed and their associated costs, benefits, and environmental impacts. TMDLs were completed for these streams by the DEQ in June 2010 and were approved by the Environmental Protection Agency in December 2010. Development of a TMDL implementation plan by the Virginia Department of Conservation and Recreation began in April 2012.

The second and final public meeting on the development of this TMDL implementation plan will be held on Wednesday, December 5, 2012, at 6 p.m. at The Powhatan School, located at 49 Powhatan Lane, Boyce, VA 22620. A meal will be provided to meeting participants, so it is requested that interested parties RSVP to Bob Slusser (telephone (540) 351-1590 or email bob.slusser@dcr.virginia.gov). The implementation plan will be available on the DEQ website the day after the meeting for public comment:

http://www.deq.virginia.gov/Programs/Water/WaterQualityInformationTMDLs/TMDL/TMDLDevelopment/DraftTMDLReports.aspx.

The public comment period for the IP will end on January 4, 2013. Written comments should include the name, address, and telephone number of the person submitting the comments and should be sent to Nesha McRae, Department of Conservation and Recreation, P.O. Box 1, Verona, VA 24482, telephone (540) 332-9238, FAX (540) 248-3069, or email nesha.mcrae@dcr.virginia.gov.

Notice of Public Meeting and Public Comment

The Department of Environmental Quality (DEQ) and the Department of Conservation and Recreation (DCR) seek written and oral comments from interested persons on the development of a total maximum daily load (TMDL) implementation plan for the Linville Creek watershed in Rockingham County and the Town of Broadway. Linville Creek was first listed as impaired on the Virginia's § 303(d) TMDL Priority List and Report due to violations of the state's water quality standard for bacteria and the general water quality standard for aquatic life (benthic impairment) in 1998. The creek has remained on the § 303(d) list for these impairments since then. Both impairment designations on Linville Creek begin at the headwaters and extend 13.55 miles to its confluence with the North Fork of the Shenandoah River.

Section 303(d) of the Clean Water Act and § 62.1-44.19:7 C of the Code of Virginia require DEQ to develop TMDLs for pollutants responsible for each impaired water contained in Virginia's § 303(d) TMDL Priority List and Report. In addition, § 62.1-44.19:7 C of the Code of Virginia requires the development of an implementation plan (IP) for approved TMDLs. The IP should provide measurable goals and the date of expected achievement of water quality objectives. The IP should also include the corrective actions needed and their associated costs, benefits, and environmental impacts. Bacteria and benthic TMDLs were completed by the DEQ for Linville Creek in March 2003 and were approved by the Environmental Protection Agency in September 2003. The TMDL report is available for review on the VADEQ website at: http://www.deq.virginia.gov/portals/0/DEQ/Water/TMDL/apptmdls/shenrvr/linville.pdf.

The first public meeting on the development of this TMDL Implementation Plan will be held on Tuesday, November 27, 2012, at 7 p.m. at the Linville Edom Ruritan Hall, 3752 Linville Edom Road, Linville, VA 22834.

The public comment period for the first public meeting will end on December 31, 2012. Written comments should include the name, address, and telephone number of the person submitting the comments and should be sent to Nesha McRae, Department of Conservation and Recreation, P.O. Box 1, Verona, VA 24482, telephone (540) 332-9238, FAX (540) 248-3069, or email nesha.mcrae@dcr.virginia.gov.

Environmental Permit - Bedford County, Virginia

Purpose of notice: The Department of Environmental Quality (DEQ) is announcing an opportunity for public comment on a permit to limit air pollution emitted by a facility in Bedford County, Virginia. The Commonwealth intends to submit the permit as a revision to its state implementation plan (SIP) in accordance with the requirements of § 110(a) of the federal Clean Air Act. The SIP is the plan developed by the Commonwealth in order to fulfill its responsibilities under the federal Clean Air Act to attain and maintain the ambient air quality standards promulgated by the U.S. Environmental Protection Agency (EPA) under the Act. DEQ is seeking comment on the issue of whether the amended permit should be submitted as a revision to the SIP.

Public comment period: November 19, 2012, through December 19, 2012.

State public hearing procedure: Interested persons may request a public hearing. The request must be made in writing to the contact listed below and be received by DEQ by the last day of the comment period. In order to be considered, the request must include the full name, address and telephone number of the person requesting the hearing and of all people represented by the requester. The request must also include: (i) the reason why a public hearing is requested; (ii) a brief statement setting forth the factual nature and extent of interest in the proposed permit, including how the operation of the facility affects the requester; and (iii) specific references to applicable terms and conditions of concern as well as suggested revisions. A public hearing may be held as required by § 10.1-1322.01 of the Code of Virginia if at least 25 requests are received in accordance with these procedures. Notice of the date, time, and location of any requested public hearing will be announced in a separate notice, and another 30-day comment period will be conducted.

Federal public hearing procedure: Interested persons may request a public hearing. The request must be made in writing to the contact listed below and be received by DEQ by the last day of the comment period. In order to be considered, the request must include the full name, address and telephone number of the person requesting the hearing and of all people represented by the requester. A public hearing will be held as required by 40 CFR 51.102(a) if a request is received in accordance with these procedures. Notice of the date, time, and location of any requested public hearing will be announced in a separate notice and another 30-day comment period will be conducted.

Permit name: State operating permit issued by DEQ, under the authority of the State Air Pollution Control Board.

Name, address and registration number: GP Big Island, LLC, 9363 Lee Jackson Highway, Big Island, Virginia 24526, Registration No. 30389.

Description of proposal: Virginia's regional haze regulation is found in Article 52 (9VAC5-40-7550 et seq.) of 9VAC5-40, Existing Stationary Sources. This regulation provides guidance for determining Best Available Retrofit Technology (BART) as required by 40 CFR 51.302, 40 CFR 51.308 and Appendix Y to 40 CFR Part 51. BART is required for any BART-eligible source which emits any air pollutant which may reasonably be anticipated to cause or contribute to visibility impairment in any federal Class I area. BART is an emission limitation based on the degree of reduction achievable through application of the best system of continuous emission reduction for each visibility-impairing pollutant emitted by an existing stationary facility established on a case-by-case basis. GP Big Island, LLC is subject to these requirements, has undergone a BART analysis resulting in the application of BART controls, and has obtained a state operating permit containing BART controls which was submitted to EPA as a SIP revision on July 17, 2008. Subsequently, GP Big Island, LLC and the department joined a mutual determination of permanent shutdown of an individual unit consisting of the No. 4 Power Boiler.

The current proposed revision consists of (i) the mutual and final determination between the source and the department, signed on January 5, 2012, that the No. 4 Power Boiler is permanently shut down and (ii) the associated state operating permit revised and issued on October 5, 2012, as the administrative mechanism to ensure continuing compliance with BART requirements. The permit was issued pursuant to Article 52 (9VAC5-40-7550 et seq.) of 9VAC5-40 (Existing Stationary Sources) and Article 5 (9VAC5-80-800 et seq.) of 9VAC5-80 (Permits for Stationary Sources) of state regulations. Because the permit has been issued, DEQ is accepting comment only on whether the amended permit should be submitted as a revision to the SIP and not on the content of the permit.

Federal information: This notice is being given to satisfy the public participation requirements of federal regulations (40 CFR 51.102). The proposal will be submitted as a revision to the Commonwealth of Virginia SIP under § 110(a) of the federal Clean Air Act in accordance with 40 CFR 51.104.

How to comment: DEQ accepts written comments by email, fax, and postal mail. In order to be considered, written comments must include the full name, address and telephone number of the person commenting and be received by DEQ by the last day of the comment period. All materials received are part of the public record.

To review proposal: The proposal and any supporting documents are available on the DEQ Air Public Notices for Plans website: http://www.deq.state.va.us/Programs/Air/PublicNotices/airplansandprograms.aspx. The documents may also be obtained by contacting the DEQ representative named below. The public may review the documents between 8:30 a.m. and 4:30 p.m. of each business day until the close of the public comment period at the following DEQ locations:

1) Main Street Office, 8th Floor, 629 East Main Street, Richmond, VA and

2) Blue Ridge Regional Office, 7705 Timberlake Road, Lynchburg VA

Contact for public comments, document requests and additional information: Jan Phillips, Administrative Supervisor, Department of Environmental Quality, Blue Ridge Regional Office, 7705 Timberlake Road, Lynchburg VA, telephone (434) 582-6218, FAX (434) 582-5125, email jan.phillips@deq.virginia.gov.

Environmental Permit - Henrico County, Virginia

Notice of action: The Department of Environmental Quality (DEQ) is announcing an opportunity for public comment on a proposed plan regarding air pollution emitted by a facility in Henrico County, Virginia. The Commonwealth intends to submit the plan as a revision to the Commonwealth of Virginia state implementation plan (SIP) in accordance with the requirements of § 110(a) of the federal Clean Air Act. The SIP is the plan developed by the Commonwealth in order to fulfill its responsibilities under the Act to attain and maintain the ambient air quality standards promulgated by the U.S. Environmental Protection Agency (EPA) under the Act.

Purpose of notice: DEQ is seeking comments and announcing a public hearing on a proposed permit to limit air pollution emitted by a facility in Henrico County, Virginia.

Public comment period: October 31, 2012, to November 30, 2012.

Public hearing: Conference Room, DEQ Piedmont Regional Office, 4949-A Cox Road, Glen Allen, VA, at 9 a.m. on November 30, 2012. A question and answer period will be held one half hour prior to the beginning of the public hearing.

Permit name: State Operating Permit issued by DEQ, under the authority of the State Air Pollution Control Board.

Name, address and registration number: Kraft Foods Global, Inc., Richmond Bakery, 6002 South Laburnum Avenue, Richmond, VA 23231, Registration No. 50703.

Description of proposal: The proposed revision consists of a determination of reasonably available control technology (RACT) for the control of emissions of volatile organic compounds (VOC) to the atmosphere from the Kraft Foods bakery located in the Henrico County, Virginia portion of the Richmond Ozone Maintenance Area. The RACT determination is being made pursuant to 9VAC5-40-7370 of state regulations. A state operating permit is being issued as an administrative mechanism to enforce the RACT

determination. The permit is being issued pursuant to Article 5 (9VAC5-80-800 et seq.) of 9VAC5-80 (Permit for Stationary Sources) of state regulations and is federally enforceable upon issuance.

A permit was issued to Kraft Foods Global by DEQ on September 19, 2007. This permit contained the RACT for the control of VOC emissions and specified certain operating conditions for the facility's Oven #1 and respective catalytic oxidizer. In an application received on August 31, 2012, Kraft Foods Global requested changes to the permit, including changes needed to accommodate replacement of the catalytic oxidizer with a more efficient regenerative thermal oxidizer. While Kraft is requesting a change in the type of control device, VOC emissions will not be affected as a result of the change because the destruction efficiency of the control device will remain the same.

Federal information: This notice is being given to satisfy the public participation requirements of federal regulations (40 CFR 51.102). The proposal will be submitted as a revision to the Commonwealth of Virginia SIP under § 110(a) of the federal Clean Air Act in accordance with 40 CFR 51.104.

How to comment: DEQ accepts written comments by email, fax and postal mail. In order to be considered, written comments must include the full name, address and telephone number of the person commenting and be received by DEQ on the last day of the comment period. Both oral and written comments are accepted at the public hearing. DEQ prefers that comments be provided in writing, along with any supporting documents or exhibits. All information received is part of the public record. Please note the proposed permit is being concurrently reviewed by EPA.

To review proposal: The proposal and any supporting documents are available on the DEQ Air Public Notices for Plans website: http://www.deq.state.va.us/Programs/Air/PublicNotices/airplansandprograms.aspx. The documents may also be obtained by contacting the DEQ representative named below. The public may review the documents between 8:30 a.m. and 4:30 p.m. of each business day until the close of the public comment period at the following DEQ locations:

1) Main Street Office, 8th Floor, 629 East Main Street, Richmond, VA, telephone (804) 698-4070, and

2) Piedmont Regional Office, 4949-A Cox Road, Glen Allen, VA, telephone (804) 527-5020.

Contact for public comments, document requests and additional information: Jennifer Hoeffner, Environmental Engineer, Department of Environmental Quality, Piedmont Regional Office, 4949-A Cox Road, Glen Allen, VA telephone (804) 527-5123, FAX (804) 527-5106, or email jennifer.hoeffner@deq.virginia.gov.

CRIMINAL JUSTICE SERVICES BOARD

Notice of Periodic Review

Pursuant to Executive Order 14 (2010) and §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, the Department of Criminal Justice Services is conducting a periodic review of:

6VAC20-230, Regulations Relating to Special Conservator of the Peace

6VAC20-250, Regulations Relating to Property and Surety Bail Bondsmen

The review of these regulations will be guided by the principles in Executive Order 14 (2010) and § 2.2-4007.1 of the Code of Virginia.

The purpose of this review is to determine whether each regulation should be terminated, amended, or retained in its current form. Public comment is sought on the review of any issue relating to each regulation, including whether the regulation (i) is necessary for the protection of public health, safety, and welfare or for the economical performance of important governmental functions; (ii) minimizes the economic impact on small businesses in a manner consistent with the stated objectives of applicable law; and (iii) is clearly written and easily understandable.

The comment period begins November 19, 2012, and ends on December 10, 2012.

Comments may be submitted online to the Virginia Regulatory Town Hall at http://www.townhall.virginia.gov/L/Forums.cfm. Comments may also be sent to Lisa McGee, Regulatory Manager, 1100 Bank Street, Richmond, VA 23218, telephone (804) 371-2419, FAX (804) 786-6344, or email lisa.mcgee@dcjs.virginia.gov.

Comments must include the commenter's name and address (physical or email) information in order to receive a response to the comment from the agency. Following the close of the public comment period, a report of the periodic review will be posted on the Town Hall and published in the Virginia Register of Regulations.

DEPARTMENT OF ENVIRONMENTAL QUALITY

Notice of Periodic Review

Pursuant to Executive Order 14 (2010) and §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, the Department of Environmental Quality will conduct a periodic review of 9VAC15-11, Public Participation Guidelines. The review of this regulation will be guided by the principles in Executive Order No. 14 (2010), Development and Review of Regulations Proposed by State Agencies, and § 2.2-4007.1 of the Administrative Process Act.

The purpose of the review is to determine whether the regulations should be terminated, amended or retained in their

current form. The department is seeking public comments on the review of any issue relating to the regulations including whether: (i) the regulations are effective in achieving their goals; (ii) the regulations are essential to protect the health, safety or welfare of citizens or for the economical performance of important governmental functions; (iii) there are available alternatives for achieving the purpose of the regulations; (iv) there are less burdensome and less intrusive alternatives for achieving the purpose of the regulations; and (v) the regulations are clearly written and easily understandable by the affected persons. In addition, the department is seeking public comments on ways to minimize the economic impact on small businesses in a manner consistent with the purpose of the regulations. The purpose of this chapter is to promote public involvement in the development, amendment or repeal of the regulations of the Department of Environmental Quality. Section 2.2-4007.02 of the Administrative Process Act (Chapter 40 of Title 2.2 of the Code of Virginia) requires that any agency required to adopt regulations must adopt public participation guidelines and specifies certain requirements that are to be included as part of these regulations. These regulations are designed with the least possible costs and intrusiveness to the citizens and businesses of the Commonwealth and to provide the necessary procedures and rules by which the statute may be administered.

The comment period begins November 19, 2012, and ends on December 10, 2012.

Comments may be submitted to Debra A. Harris, Planning and Policy Specialist, Office of Regulatory Affairs, Department of Environmental Quality, Post Office Box 1105, Richmond, VA 23218 (deliveries can be made to 629 East Main Street, Richmond, VA 23219), telephone (804) 698-4209, FAX (804) 698-4346, or email debra.harris@deq.virginia.gov. Alternatively, comments may be submitted online to the Virginia Regulatory Town Hall at http://townhall.virginia.gov/L/Forums.cfm. Please note, comments must include the commenter's name and address (physical or email) in order to receive a response to the comment from the agency. Following the close of the public comment period, a report of the periodic review will be posted on the Town Hall and published in the Virginia Register of Regulations.

DEPARTMENT OF HOUSING AND COMMUNITY DEVELOPMENT

Request for Public Comment - Boundaries of Planning Districts

The Regional Cooperation Act, passed by the General Assembly in 1995, places great emphasis on the planning district commissions serving as a forum for discussion of regional issues and identification of ways to promote regional cooperation. Section 36-139.7 of the Code of Virginia requires that the Virginia Department of Housing and Community Development (DHCD) conduct a periodic review of the boundaries of planning districts. It requires that DHCD consider, at a minimum, the following criteria:

1. Recognition of communities of interest among the governmental subdivisions;

2. Recognition of common economic and market interests;

3. Ease of communications and commissioner travel time;

4. Federal metropolitan statistical area boundaries;

5. A population base adequate to ensure financial viability;

6. Geographic factors and natural boundaries; and

7. The wishes of the governmental subdivisions within or surrounding the planning district, as expressed by resolution of the governing body.

DHCD will conduct its review in two phases: a period of written public comment and, if warranted, public hearings.

Written public comment: This notice begins the period for written public comment. Letters should concisely address the need for retaining or modifying the current boundaries of a given planning district using the criteria outlined above or other factors that affect the viability or effectiveness of the planning district commission in carrying out its duties. The deadline for written public comment is December 19, 2012. Comments should either be emailed to susan.williams@dhcd.virginia.gov or addressed to Susan B. Williams, Local Government Policy Manager, Department of Housing and Community Development, Main Street Centre, 600 East Main Street, Suite 300, Richmond, VA 23219.

In the event that there are sufficient and compelling requests for boundary adjustments, DHCD will conduct public hearings within the affected planning districts. DHCD staff will consider all comments received through written responses and public hearings and, subject to the provisions of the Administrative Process Act, make adjustments to the boundaries of planning districts as it deems advisable.

Any such hearings will be advertised in local newspapers and notices will be sent to local government and planning district offices. The purpose of such hearings will be to gather information from local officials, organizations and residents as to why a boundary adjustment is warranted and the advantages such an adjustment would provide to each affected planning district in order to ensure that all affected parties have had adequate opportunity to share their views and perspectives on any proposed adjustment.

For additional information, please contact Susan Williams by regular mail at the address provided above; by email at susan.williams@dhcd.virginia.gov, or by telephone at (804) 786-6508.

VIRGINIA WASTE MANAGEMENT BOARD

Notice of Periodic Review

Pursuant to Executive Order 14 (2010) and §§ 2.2-4007.1 and 2.2.-4017 of the Code of Virginia, the Department of Environmental Quality on behalf of the Virginia Waste Management Board will conduct a periodic review of 9VAC20-11, Public Participation Guidelines. The review of this regulation will be guided by the principles in Executive Order No. 14 (2010), Development and Review of Regulations Proposed by State Agencies, and § 2.2-4007.1 of the Administrative Process Act).

The purpose of the review is to determine whether the regulations should be terminated, amended or retained in their current form. The department and the board are seeking public comments on the review of any issue relating to the regulations including whether: (i) the regulations are effective in achieving their goals; (ii) the regulations are essential to protect the health, safety or welfare of citizens or for the economical performance of important governmental functions; (iii) there are available alternatives for achieving the purpose of the regulations; (iv) there are less burdensome and less intrusive alternatives for achieving the purpose of the regulations; and (v) the regulations are clearly written and easily understandable by the affected persons. In addition, the department and the board are seeking public comments on ways to minimize the economic impact on small businesses in a manner consistent with the purpose of the regulations. The purpose of this chapter is to promote public involvement in the development, amendment or repeal of the regulations of the Virginia Waste Management Board. Section 2.2-4007.02 of the Administrative Process Act (Chapter 40 of Title 2.2 of the Code of Virginia) requires that any agency required to adopt regulations must adopt public participation guidelines and specifies certain requirements that are to be included as part of these regulations. These regulations are designed with the least possible costs and intrusiveness to the citizens and businesses of the Commonwealth and to provide the necessary procedures and rules by which the statute may be administered.

The comment period begins November 19, 2012, and ends on December 10, 2012.

Comments may be submitted to Debra A. Harris, Planning and Policy Specialist, Office of Regulatory Affairs, Department of Environmental Quality, Post Office Box 1105, Richmond, VA 23218 (deliveries can be made to 629 East Main Street, Richmond, VA 23219), telephone (804) 698-4209, FAX (804) 698-4346, or email debra.harris@deq.virginia.gov. Alternatively, comments may be submitted online to the Virginia Regulatory Town Hall at http://townhall.virginia.gov/L/Forums.cfm. Please note, comments must include the commenter's name and address (physical or email) in order to receive a response to the comment from the agency. Following the close of the public comment period, a report of the periodic review will be posted on the Town Hall and published in the Virginia Register of Regulations.

STATE WATER CONTROL BOARD

Notice of Periodic Review

Pursuant to Executive Order 14 (2010) and §§ 2.2-4007.1 and 2.2.-4017 of the Code of Virginia, the Department of Environmental Quality on behalf of the State Water Control Board will conduct a periodic review of 9VAC25-11, Public Participation Guidelines. The review of this regulation will be guided by the principles in Executive Order No. 14 (2010), Development and Review of Regulations Proposed by State Agencies, and § 2.2-4007.1 of the Administrative Process Act.

The purpose of the review is to determine whether the regulations should be terminated, amended or retained in their current form. The department and the board are seeking public comments on the review of any issue relating to the regulations including whether: (i) the regulations are effective in achieving their goals; (ii) the regulations are essential to protect the health, safety or welfare of citizens or for the economical performance of important governmental functions; (iii) there are available alternatives for achieving the purpose of the regulations; (iv) there are less burdensome and less intrusive alternatives for achieving the purpose of the regulations; and (v) the regulations are clearly written and easily understandable by the affected persons. In addition, the department and the board are seeking public comments on ways to minimize the economic impact on small businesses in a manner consistent with the purpose of the regulations. The purpose of this chapter is to promote public involvement in the development, amendment or repeal of the regulations of the State Water Control Board. Section 2.2-4007.02 of the Administrative Process Act (Chapter 40 of Title 2.2 of the Code of Virginia) requires that any agency required to adopt regulations must adopt public participation guidelines and specifies certain requirements that are to be included as part of these regulations. These regulations are designed with the least possible costs and intrusiveness to the citizens and businesses of the Commonwealth and to provide the necessary procedures and rules by which the statute may be administered.

The comment period begins November 19, 2012, and ends on December 10, 2012.

Comments may be submitted to Debra A. Harris, Planning and Policy Specialist, Office of Regulatory Affairs, Department of Environmental Quality, Post Office Box 1105, Richmond, VA 23218 (deliveries can be made to 629 East Main Street, Richmond, VA 23219), telephone (804) 698-4209, FAX (804) 698-4346, or email debra.harris@deq.virginia.gov. Alternatively, comments may be submitted online to the Virginia Regulatory Town Hall at

http://townhall.virginia.gov/L/Forums.cfm. Please note, comments must include the commenter's name and address (physical or email) in order to receive a response to the comment from the agency. Following the close of the public comment period, a report of the periodic review will be posted on the Town Hall and published in the Virginia Register of Regulations.

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 use the Regulation Information System (RIS) to file regulations and related items for publication in the *Virginia Register of Regulations*. The Registrar's office works closely with the Department of Planning and Budget (DPB) to coordinate the system with the Virginia Regulatory Town Hall. RIS and Town Hall complement and enhance one another by sharing pertinent regulatory information.

ERRATA

STATE WATER CONTROL BOARD

Title of Regulation: **9VAC25-120. General Virginia Pollutant Discharge Elimination System (VPDES) Permit Regulation for Discharges from Petroleum Contaminated Sites, Groundwater Remediation and Hydrostatic Tests.**

Publication: 29:4 VA.R. 857-875 October 22, 2012.

Change to Final Regulation:

Page 860, 9VAC25-120-70 C 2 b, line 5, after "under subsection" strike "A" and insert "B"

VA.R. Doc. No. R11-2774; Filed October 23, 2012, 1:47 p.m.

BOARD OF FUNERAL DIRECTORS AND EMBALMERS

Title of Regulation: **18VAC65-30. Regulations for Preneed Funeral Planning.**

Publication: 29:3 VA.R. 587-592 October 8, 2012.

Change to Fast Track Regulation:

Page 588, 18VAC65-30-110, existing subsection E was missing from publication. Reinsert:

"E. The contract buyer shall have the right to change the contract provider and the trustee at any time prior to the furnishing of the services or supplies contracted for under the preneed contract."

VA.R. Doc. No. R13-2386; Filed October 31, 2012, 2:05 p.m.